MEDICAL READINESS OF THE ARMED SERVICES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON MANPOWER AND PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

MAY 5, 26, 1982

Printed for the use of the Committee on Armed Services

U.S. GOVERNMENT PRINTING OFFICE
95-673 O WASHINGTON: 1982

5201-22

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MEDICAL READINESS OF THE ARMED SERVICES

WEDNESDAY, MAY 5, 1982

U.S. SENATE,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, D.C.

The subcommittee met in open session at 9:10 a.m. in room 224, Russell Senate Office Building, Hon. Roger W. Jepsen, chairman, presiding.

Present: Senator Jepsen.

Staff present: Anthony J. Principi, counsel; David S. Lyles, professional staff member; Ralph O. White, research assistant; Jacquie S. O'Grady, staff assistant.

Also present: Jon Etherton, assistant to Senator Jepsen; Greg Pallas, assistant to Senator Exon.

OPENING STATEMENT BY SENATOR ROGER W. JEPSEN, CHAIRMAN

Senator JEPSEN. The Subcommittee on Manpower and Personnel will come to order.

The Subcommittee on Manpower and Personnel convenes today to receive testimony on the subject of medical readiness in the armed services. I am pleased to welcome before the subcommittee Dr. John Beary, Acting Assistant Secretary of Defense for Health Affairs; Gen. Paul Myers, U.S. Air Force, Surgeon General; Vice Adm. William Cox, U.S. Navy, Surgeon General, and Lt. Gen. B. T. Mittemeyer, U.S. Army, Surgeon General.

In your prepared text each of you has indicated that your primary mission is to provide medical support to our soldiers, sailors, and airmen in time of war. Certainly, there can be no greater requirement than to insure that the young men who fall in battle in defense of this country receive adequate medical care.

I could not begin to tell you how strongly I feel about this issue and the concern that I have that only a very small fraction of our wounded can expect to receive the emergency surgery they would require in war.

I hope that today's hearings will focus attention on this critical area of our military preparedness and afford us the opportunity to begin to identify and correct our medical shortfalls.

I have a number of comments related to specific issues which I shall address during the question and answer period.

Your written satements will be made a permanent part of the record and you may proceed as you wish. I would ask that your oral testimony be kept to a minimum as debate on the DOD authorization bill is commencing later this morning and we, especially those of us on the Armed

Services Committee, are making it a point to be on deck and on the floor when the debate moves. There are going to be some debates and controversy as it unfolds, we have reason to believe.

So, at this time, Dr. Beary, you may proceed.

STATEMENT OF DR. JOHN BEARY, ACTING ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. BEARY. Mr. Chairman and members, I am pleased to appear before you today to discuss the medical readiness of our Armed Forces.

In the past, medical readiness has not received the attention it deserved. Unfortunately, it still does not have the public interest that is afforded some of our other defense needs. Nevertheless, it remains a serious problem which jeopardizes any soldier, sailor, airman, or marine who might be wounded or injured defending the vital interests of the United States in today's troubled world.

As the previous Assistant Secretary of Defense for Health Affairs testified to the House Appropriations Committee last year, the brutal fact is that if we went to war today in Europe, in Southeast Asia, or in Korea, we could only provide surgery for about 1 out of 10 of those who would be wounded. Moreover, the casualty predictions are conservative. They assume casualty rates toward or at the bottom of the historic range for each service's characteristic type of combat in hard-fought but successful operations.

We are working hard to get well, but it is going to take some time. I might just comment briefly on the etiology of this problem.

In 1973, when the draft ended, so ended our so-called Berry plan, whereby medical residents were given deferments and entered into active duty when they completed their training. When that program ended suddenly there was a severe drop in manpower. Fortunately, the scholarship program and the university are rectifying that problem: We have good numbers of people on active duty today. The surgical specialty mix still needs some attention.

The next step we must take is to turn our attention toward the Reserves because the ideal medical manpower mix to address wartime requirements would be about two-thirds in the Reserves and a third on active duty. I will speak to that a bit more fully later in the testimony.

Since I joined the Defense Department last spring, improving medical readiness has been my No. 1 priority. Several initiatives are underway, and old ones have been accelerated to bring us to the level of preparedness necessary to provide medical support to our combat forces.

Today, I will briefly describe DOD's current peacetime and wartime medical capabilities in Europe and the Pacific, describe medical support for the rapid deployment joint task force, explain how we determine our requirements for wartime medical resources, and touch on the subjects of standardization of the field hospital systems. Reserve manpower strength, and our contingency hospital system.

I will, to help save time, touch just briefly on theater medical systems and move ahead to Reserve areas which I think deserve more emphasis.

In Europe today the services operate 22 hospitals. Of these, eight are located in relatively secure areas of possible wartime theater operations and would be expanded for war. The staffs of the remaining 14 hos-

pitals would quickly relocate to man pre-positioned deployable units at wartime. The total bed capacity and OR capability of the peacetime hospitals are, however, inadequate to meet the wartime needs. Even when expanded, these hospitals could meet less than 5 percent of the services' wartime bed requirements and even less than that of the operating room requirements.

The services have programs to overcome this shortfall by acquiring deployable hospitals.

The situation in the Pacific is similar. The situation in Southwest Asia is even more complex because of logistical problems, and lack of the extensive host-nation support you are more likely to see in a developed area such as Western Europe. The details are in the written testimony and I will move ahead now to the hospital ship topic.

I think it is important to spend just a few minutes on this because there has been some controversy and debate attached to this subject over the past couple of years.

A hospital ship capability is absolutely essential for medical support of any sizable amphibious forced entry military operation. The medical capabilities of our amphibious ships are constrained by the combat mission; they are built to carry troops, not to stay and tend to the wounded—although they can do that for a couple of days.

Shore-based hospitals cannot be used until a beachhead or other safe area is secured and facilities are set up. At the initial stages when casualties will be heaviest only—and I emphasize "only"—a hospital ship can meet their needs for definitive care.

The 24 operating-room, 2,000-bed hospital ship capability—half of which we have budgeted for fiscal year 1983—will meet a conservatively estimated requirement for the sort of force structure we would be considering deploying.

As we told the House Subcommittee on Defense Appropriations last year, the only ship which appeared to have this potential for prospective conversion was the SS *United States*: The fiscal year 1982 budget submitted to Congress provided $10 million for lead items for her commission. However, the Navy subsequently identified a more promising alternative to the SS *United States* and the request for $10 million was dropped.

The preferred alternative, which is budgeted for $300 million in fiscal 1983, is for conversion or construction of hospital ships—two or more hulls rather than one—thus, to get the 2,000-bed capability, ships would be converted by civilian industry, followed by a Navy purchase of the ships.

At the moment, the Navy is reviewing hospital ship proposals. They will be narrowed to finalists in about 2 weeks, with final source selection made early in 1983. As Secretary of the Navy John Lehman testified, this solid program will provide the essential capability in a cost-effective and timely way.

The next item is deployable hospitals.

Senator JEPSEN. Excuse me, how many hospital ships do we have now?

Dr. BEARY. We have none. The *Sanctuary* was the last one that we had operational. She is tied up in the James River and all the military professionals agree she is totally inadequate to meet our requirements. You cannot quite kick a hole in the bottom of her but she has not been weathering all that well. She was built in 1945. So, at the moment

the United States has no hospital ships and we do have a lot of marines who might need one.

Mr. PRINCIPI. Why has there been a delay in the final selection of the new hospital ship.

Dr. BEARY. I think I would have to defer questions about the schedule to Admiral Cox, as regards how likely we are to stay on schedule with that thing. It is my understanding that the finalists are supposed to be nailed down in about 2 weeks, and then there should be a good timetable to move rapidly along.

It has, unfortunately slipped a year since I came. Originally we thought we would have it in the water in fiscal year 1985 but now it looks like fiscal year 1986 because of the tempo of the selection process.

Senator JEPSEN. If we should have a firefight where we would have need of a hospital ship between now and 1986, what do we do?

Dr. BEARY. Senator, I am afraid we would be doing what the British had to do recently, going out and finding the best passenger ship you can, put something together, and hope it works.

Senator JEPSEN. That is not acceptable.

Mr. PRINCIPI. Admiral Cox, did you want to comment?

Admiral Cox. If I may, Mr. Chairman. The time relationships for making the decision are now on schedule. It is an extremely complex proposition to design a tertiary or definitive care facility of that nature, get firm bids, and make a selection. This process currently resides in the Naval Sea Systems Command, and it is my understanding that they are on target.

Senator JEPSEN. I would like to pursue it just a little for the record—to make sure that I understand correctly.

Again I will ask the same question: Is it correct, to say that we do not have a hospital ship facility ready to go today, nor are we scheduled to have one, even though we are on schedule, until 1986?

Admiral Cox. That is essentially correct, sir. As an interim "something is better than nothing" kind of fix, there are deployable facilities that we will address later on.

There is also an improvement in the capability of the medical spaces on the amphibious assault ship, like the attack landing platform helicopter that has medical spaces which could be pressed into service by the battle commander in the amphibious objective area and which has stabilization and life-saving capability. However, it is nowhere near the requirement to meet any reasonable scenario that might be developed.

So, essentially, that is the gap. We do not have the mobile afloat capability to meet the medical support requirements at this time.

Senator JEPSEN. Why do we not have this capability?

Admiral Cox. To be perfectly candid, there has been a 10-year neglect of medical support requirements. We do not have the deployable land-based facilities required at this time either.

Senator JEPSEN. It is not new that anything has been neglected for 10 years in the military. But it has not only been neglected, it sounds like it has been ignored completely.

Admiral Cox. I use an expression that it was continuously put in the "too hard baskets." When I left Washington in 1978 a long study

had just come out called an Alternative to a Dedicated Hospital Ship which arrived at the same conclusion that we had arrived at before the study was done.

Senator JEPSEN. Just in verbally examining things here, it also appears to me that certainly on a peacetime basis we ought to use all these things in a dual role. We prepare and we hope for "peace through strength,"—at least many of us who think we understand the situation do.

I could see no finer symbol of assistance and help in peace for all kinds of natural disasters in other countries who have earthquakes and have all kinds of serious things than the finest medical facility ever known in the history of mankind to be present.

And, of course that medical facility would be up front for our men and women in the service. I happen to believe that if we ever have a fire fight we owe it to our military to have absolutely every support with no exception. But this can have such a dual, a triple role, of playing such an important part in the whole scheme of the image and so on for our country.

I am probably not saying anything new to you. But I am surprised, and I will tell you right now, I think we are going to work on doing something other than waiting until 1986.

But, let us go on.

Dr. BEARY. The next subject is deployable hospitals. The fiscal year 1983 budget you now have before you also requests funding for a vitally necessary increase in our shore-based deployable hospital capability. In a typical scenario the hospital ship will support the initial stages until sites are secured on shore, and then these large hospitals with many operating rooms will be set up. Again, the focus is on surgery, because that is what combat medicine is all about.

The Navy budget contains a total of $75 million, which will procure part of the medical support needed by the Navy and Marine Corps components of the RDF. This will provide all the equipment and supplies required to operate 1,250 beds of both resuscitative and definitive care capability.

In addition, the DOD budget requests approximately $175 million to procure Air Force and Army deployable medical systems.

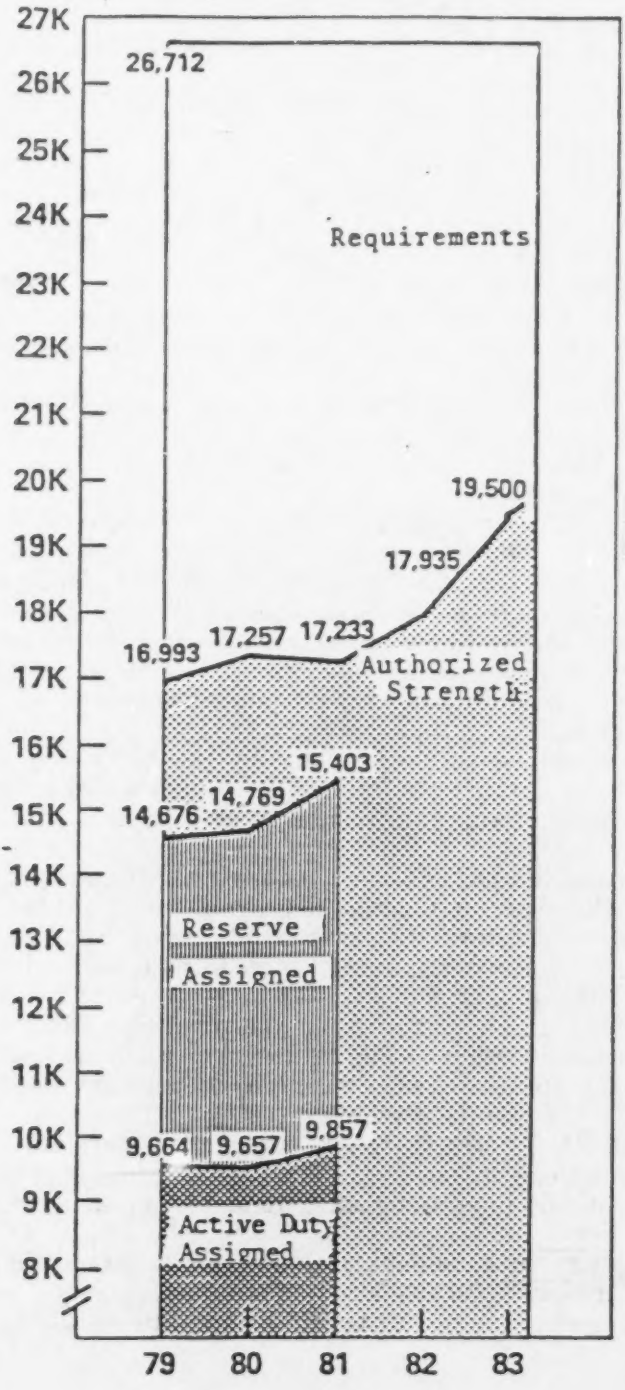
There is no question that in the past there has been little interservice coordination in the development of field medical systems. However, this is no longer the case. We are in the final stages of issuing a Department of Defense instruction governing the standardization of field medical systems. The instruction requires that the services procure only those systems which have been developed under the direction of the standardization steering group.

The important point there is that all three services will be caring for the same casualty loads and if something breaks down in one system, you must be interchangeable. It has a commonsense feature that speaks for itself.

Turning now to personnel. I would like to have this first chart of the physicians, and just speak to how we generate requirements from it. I will talk more to the points made about manpower later.

TABLE I

PHYSICIANS



Essentially what we see here, if you note the break of scale of total DOD physicians, is that the active duty assigned are about 10,000 in number and another 5,000 are available at the present time in the Reserves.

This is the authorization, the budgetary feature. But here is the requirement line; the question is, how is that 26,000 figure arrived at?

It is based on the sort of work load we would see in a combat theater. We have 2 million men and women in our armed services now and another million in the Reserves. When we look at what force structure would be in a theater, we note the population that is at risk of wounding, deriving our estimates of casualty rates from historical experience in different conflicts the United States has been involved in, from recent events such as the Arab-Israeli conflict, and so on. On the theoretical side also, we know what the approximate wounding rates will be from modern conventional weapons.

When you multiply the force at risk by the wound injury rates you generate a workload. That workload can be translated into number of doctors needed, beds needed, and number of operating rooms needed. We will come back to that in a moment.

Turning now to Reserve physicians. As I mentioned, this is a priority area for me; many of these proposals I will discuss are based on my own 12 years of experience with the Reserves.

As I said, right now the Reserves represent about a third of our manpower—they should represent two-thirds. As General Mittemeyer would say, the Army force structure is such on the medical side that two-thirds of his assets are in the Reserves.

TABLE II

GENERAL SURGEON

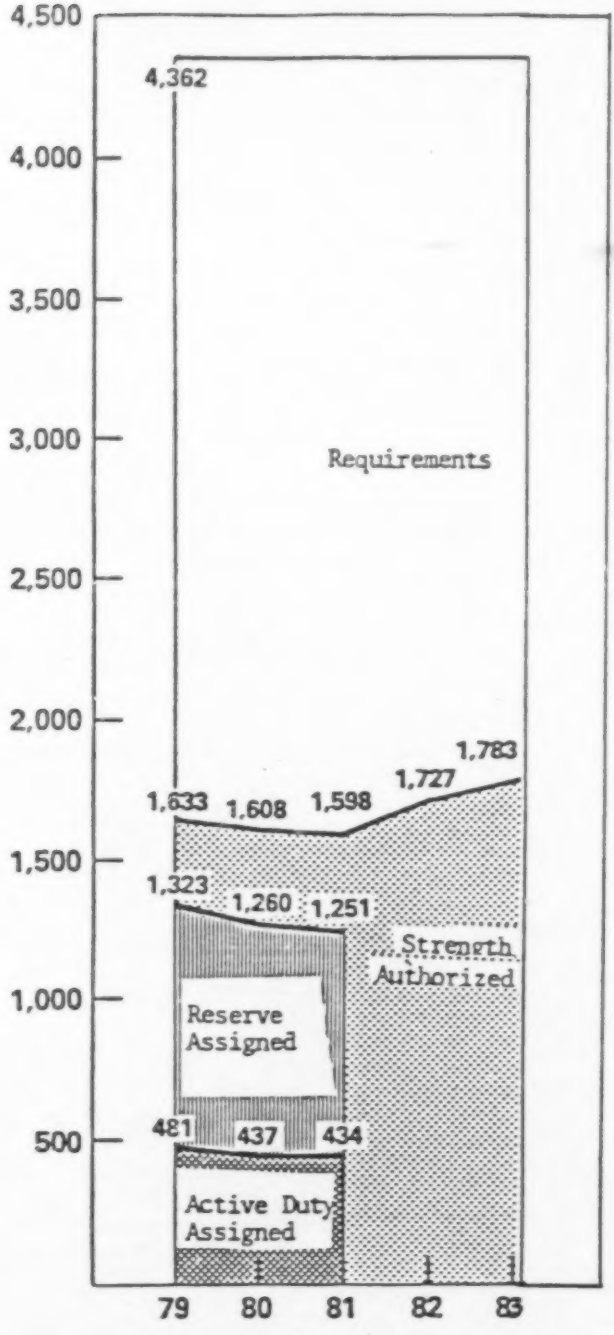
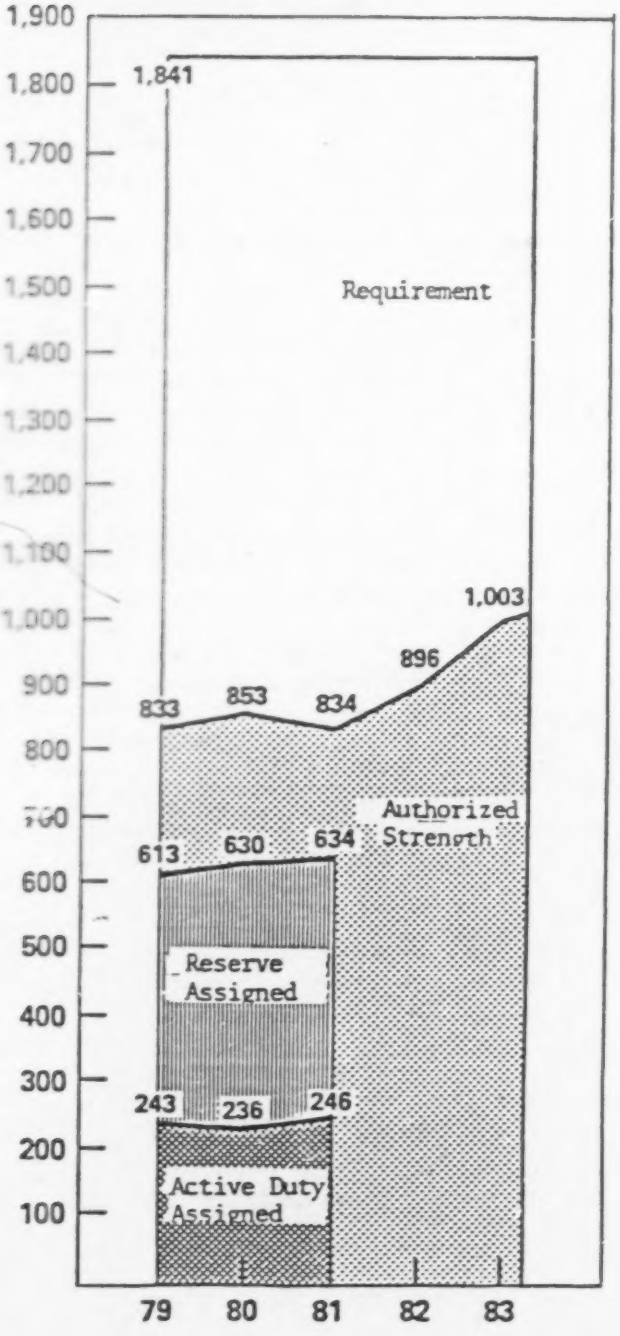


TABLE III

ORTHOPEDIC SURGEON



Can I see the Reserve chart? The Reserve billets, those that are budgeted right now, are only about 50-percent manned. The largest shortfalls are in the surgical area, again the key part of providing care in the combat theater.

Surgical capability has been of increasing concern in the manpower staffing of the Reserves. Just to cite an example; when I was working in New York City I was a member of a Reserve unit that was supposed to be staffed with 20 doctors with surgical missions. There were actually only six of us in it. This was in Metropolitan New York, where you have more doctors per square mile than just about any place in the country.

In this unit, again, we were supposed to be doing surgery, not office practice. We had one pediatrician, three psychiatrists, an internist—myself—and a gynecologist. So, we were not going to make much of a contribution to these kinds of plans that we are talking now about being able to support.

That is not unlike what I have found in Maryland and other places where I have served in the Reserves. I will go into some of the reasons why.

Now, if I could have those manpower charts we will look at the physician manning again. I discussed how we generated this requirement line and that we are prepared to defend the assumptions that went into generating that number.

As you can see, it is a good, long distance from total assets here to our requirement. We cannot afford to have all these people on active duty; they would not be busy enough and so forth and so on. They need to be in the Reserves, which is the cost-effective way to have this manpower available when needed.

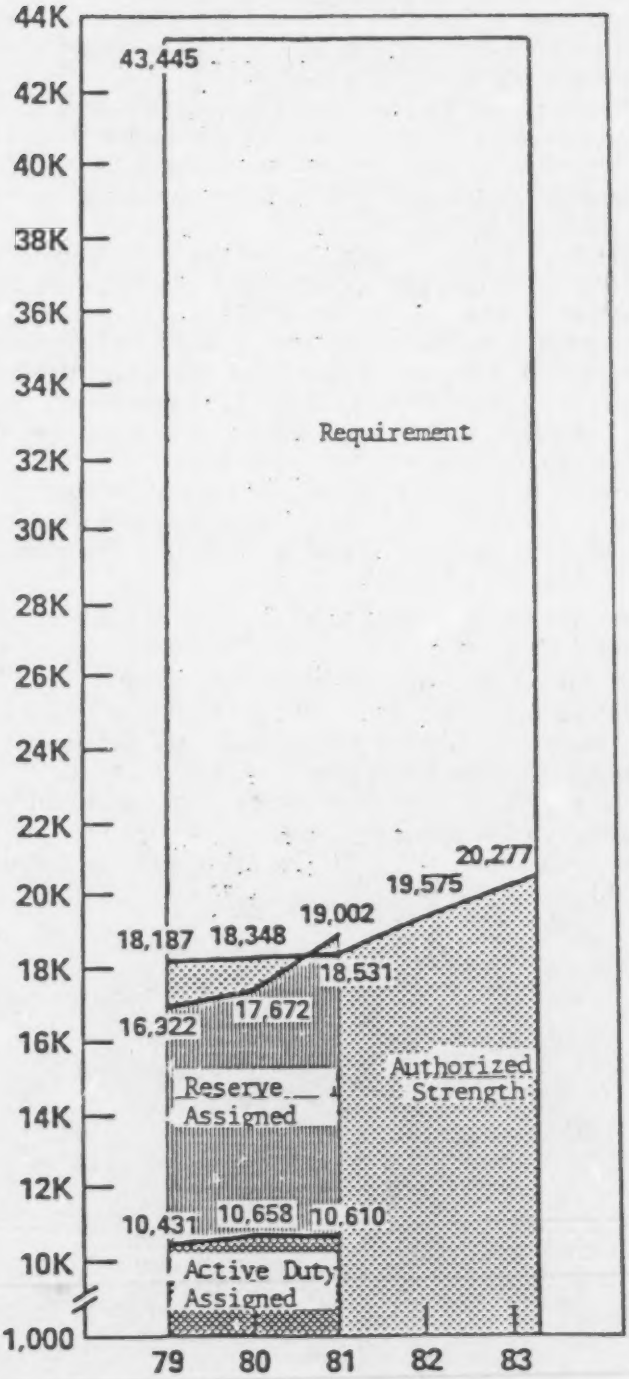
If we can now see the surgical side. The general surgeons, those who take care of wounds in the extremities, belly surgery and so forth, are vital to support of the Army and Marines. I am afraid they are a little anemic in our manpower figures here. We have 400 on active duty and another 800 in the Reserves; we need 4,000. Again, if you think about the size of the supported force, 4,000 surgeons, general surgeons, is a conservative number; we are not exaggerating our needs at all.

Senator JEPSEN. Are you going to talk about recruiting, how you are trying to resolve that?

Dr. BEARY. Yes, I will. We will just flash up the nurse slide here quickly.

TABLE IV

NURSES



We should not forget, the doctor is not the one who does all the work. In a medical team we must have other valuable professionals, such as nurses, to do our job; and we have 18,000 all told. We need 43,000.

With regard to some of the steps we have taken to get well in the Reserves; we have a full-time director for Reserve forces planning, Lieutenant Colonel Chester, who is here with us today. He is devoting his energies to solving this problem.

We now have a Reserve Components Medical Council, through which admirals and generals from the Reserve components now have direct input into my office to provide first-hand feedback on what is going on, if things are working or they are not working so we can move urgently to solve problems.

One of the first actions recommended by the Council, which is in effect now, is to accelerate the appointment process, reducing the processing time from over a year in some cases to a maximum of 30 days. We are not taking any risk there of appointing bad people; these people are prescreened. They must have a recommendation from a medical society or the department chairman of a medical school. When we did this before, during the Korean conflict, we found that we had a 99.7 validity rate for that kind of procedure.

So, we are not taking any risks. The regular paperwork can catch up later, but you will not have that happen again what happened to the only orthopedic surgeon I had recruited in the New York area, who dropped out after 11 months. He said:

> If you cannot get the paperwork done any quicker than this—I am not exactly unknown—then I just do not have the patience to stay with it.

So, now that little piece of essential work is done.

Another important issue is training requirements. As I said, we are short of surgeons. We are not so badly off for pediatricians and psychiatrists and others, but a good surgeon, particularly in the residency, is working 80, 90 hours a week. So, when you add in some time for the family you have to have quite an energy level and discipline and dedication to then get out to the armory for a couple of days a month to drill.

We are trying to help out these highly trained people. Every day that they are going to work they are doing two or three cases in the operating room, and that is training for their appropriate wartime skills. My goal is just to have them on my computer so I can call them up if needed. So, I am willing to do some things to meet their life style needs, such as counting three or four operations as a drill credit. Appropriate continuing medical education seminars, and what have you, are counted as a field credit.

When they get more established practices, hopefully they will have been interested in military medicine, will stay with the program, and we will have available the kind of doctor you would want operating on you, or me, or our families if we were wounded.

But we are not meeting the market forces right now and that is what these initiatives are directed toward doing.

The third important point I would emphasize, is that we are trying to set up some Reserve detachments at civilian medical schools. They will be affiliated regular Reserve units. We are not doing anything in force structure, we are just giving the units a mechanism to get more people through these units. I have already said that the doctors are not there yet in the units. They are in the medical centers, and that is where we must go to get them. This is simply a function of Sutton's law: Big university hospitals are where the doctors and surgeons, and nurses, and so forth, are. So, if we have good programs in these areas, hopefully success will breed success. But we are going to have to meet the needs of these people or it is not going to work.

We have submitted two proposals to Congress and we need your support for them. One is DOD 97–47, which standardizes the initial Reserve deployment physicians.

The other one is not to require Senate confirmation for people appointed up to the grade of lieutenant colonel. That requirement tends to slow things down, and confirmation is a very routine thing anyway. Probably you have never asked a question about one of these people that has come before you. So, that would be a valuable administrative enhancement, if you see your way clear to support us.

My final topic is the contingency hospital system, about which you have been hearing a great deal recently in the press. Some of the antimilitary doctors have had some comments on it. The bottom line is that the Department of Defense currently operates 18,000 beds. Our requirement generator shows we need access to another 50,000 beds. If we build them, it will cost $5 billion to do it. So, the reasoning goes why not make arrangements in peacetime with civilian hospitals and have this capability ready for our servicemen if we need it?

In addition, this has to do with, just as you suggested with the hospital ship, a way to serve the needs of the United States in peacetime. The United States has no national disaster response capability now. If, say, a major earthquake were to hit California and destroy most of the medical facilities in Los Angeles and San Francisco, how would they cope with the scale of injuries that would result from such a national disaster?

Well, this program provides a transportation network, communications and training to take care of things of that sort.

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Senator JEPSEN. You were telling me you had some resistance to that from some areas of doctors, the MA, what area, and why?

Dr. BEARY. Well, I think they are people who actually have a social protest agenda in mind. They claim their opposition is because of antinuclear concerns. But as you know, anyone who has been to a medical library in the last 10 years recognizes that that is ridiculous.

Just two quick points: The CMCHS system has 50,000 beds in it. A single one-megaton bomb can injure 500,000 people. How could anyone claim that the CMCHS addresses the nuclear case? Second: The burn rate in conventional warfare, tanks, et cetera, you see about a 10-percent burn rate. In the nuclear scenarios, of among those who are injured, it is 50 percent or greater. So, that just tells me that people who protest to this do not have nuclear concerns, they have more of a unilateral disarmament type of concern.

It is just appalling to hear another physician say something that in effect denies medical care to our forces.

Senator JEPSEN. This denies medical care to men and women of our country, citizens of our country, let alone people in uniform in the event of emergency.

Dr. BEARY. Sorry, I did not hear you.

Senator JEPSEN. What they are saying is, they are denying contingency planning and therefore medical care in the event of emergencies of all kinds, not only to men and women in uniform, but our civilians.

Dr. BEARY. Yes, one could make that interpretation.

Senator JEPSEN. The intent of their heart may be right, but they certainly are a little bit off base.

Dr. BEARY. Well, it is an odd argument: saying to get rid of the military medical system to prevent war is like saying to abolish umbrellas to prevent rain showers. It does not make any sense any way you look at it.

General MYERS. Ten days ago I had the opportunity to meet with half a dozen people who represent that element from a Northeastern medical establishment that is very well known. What came out of that meeting was a perception on my part that they see a "doomsday" for which nothing can be done and because of that, why do any planning?

This we countered by saying that we do not subscribe to that doctrine; that we make concrete plans to handle those things that we feel we have to face up to and not turn away from them with this "doomsday" concept. That is essentially what I got out of my experience with them.

Dr. BEARY. Before leaving this subject, let me note that I put a copy of an article I wrote for the New England Journal on this subject in the record. Let me note also that one of the arguments of our critics has been that Congress has been excluded from these deliberations. Of course, that is nonsense. Congress has been involved since 1979. So, if your committee saw it proper to make a comment on your assessment of the value of this plan, I think that would be very useful.

That concludes my testimony. Thank you, Mr. Chairman.

Senator JEPSEN. General Myers?

STATEMENT OF LT. GEN. PAUL W. MYERS, U.S. AIR FORCE, SURGEON GENERAL

General MYERS. Thank you, Mr. Chairman. I welcome the opportunity to discuss with you the activities of the Air Force Medical Service in building its readiness capability.

In late 1978, we began to generate specific programs to improve our capabilities to support combat operations. May I speak first to triservice cooperative efforts.

There has been joint development and procurement of war reserve materiel. I am proud of our joint service readiness training initiatives, that is, the triservice combat casualty care course, medical red flag exercises, and battlefield medicine, of course; and under development is a self-aid and buddy care program.

Chemical warfare defense is being addressed vigorously in all services, with a joint prioritization of research and development needs.

A triservice military field medical system standardization steering group has been established, as well as a military medical coordinating groups for materiel readiness. The objectives are to eliminate duplication, to determine the degree of equipment commonality, and to promote the standardization of medical systems.

A review of commonality of medical equipment for fourth echelon assemblages—those outside the combat zone—has been completed, and Air Force and Navy programs are 99.5 percent common.

Concerning the wartime theater medical organization, the Air Force has adopted a "four echelons of care concept." Plans for materiel and manpower are geared to that concept.

As we look at staffing, sufficient medical manpower has been a continuing concern. Manning has improved significantly but we are short of physicians in key specialties.

The total manpower to support our projected readiness capability has been identified. For example, in critical wartime specialties we have only 16 percent of our needed surgeons; 9 percent of our needed orthopedists, and 26 percent of our needed operating room nurses.

In determining wartime requirements, we have looked at casualty rates that are based upon intelligence data, weapons effects, historical data—and the Secretary spoke to those. We then use a triservice data base to compute the bed and physician requirements.

Our Reserve and Guard manning continues to improve. Overall medical staffing in the Reserve program this past year was 106 percent in the unit program and 87 percent in the individual mobilization augmentee program. Staffing in the Guard was 96 percent. The Air Force 5-year plan is to increase the number of Air Force Reserve medical personnel from 5,500 to almost 10,000.

Our medical materiel planners have projected our war reserve materiel needs to support combat operations. There are sufficient dollars to meet those requirements that are being planned. This material is pre-positioned, insofar as possible, in the theater where it is most likely to be needed.

In an effort to intensify the program to upgrade and modernize our health care facilities worldwide, we have initiated a clinical and hospital accelerated modernization program, a 5-year effort to eliminate serious facility constraints, with a total requirement of $1.7 billion.

As noted, there are medical facilities in Europe that have suffered from austere funding problems.

Wartime construction planning is exemplified by the hospital planned for Osan Air Base in Korea with readiness features included in its design. We have developed a 5-year medical warehouse construction program which will match the delivery of those war reserve materiel hospital assets. We have established an off-base siting program.

We have approached the Army and the Navy with a proposal for sharing hospital beds in-theater and have at this moment designated 38 of our medical facilities in the continental United States for assigned contingency expansion missions.

I would say in conclusion, sir, that the attainment of an effective readiness posture is a complex and expensive undertaking. Exquisite timing and precise planning are needed to acquire the manpower addition, the adequate support personnel, facility modernization, and sizing to meet both peacetime and wartime requirements.

A significant step toward achieving the above would be the legislative recognition of a peacetime benefit mission with attendant growth in staffing and facilities. That would increase our readiness capability for a wartime effort.

Many improvements in readiness have been made. Much remains to be done. We will be happy to answer any questions, sir.

Senator JEPSEN. Thank you, General. Your prepared statement will be inserted in the hearing record.

[The prepared statement of Lieutenant General Myers follows:]

PREPARED STATEMENT OF LT. GEN. PAUL W. MYERS, SURGEON GENERAL, U.S. AIR FORCE

Mr. Chairman and Members of the Committee: I am Lieutenant General Paul W. Myers, U.S. Air Force Surgeon General. I welcome the opportunity to discuss with you the activities of the Medical Service in building its readiness capability.

The Army, Navy and Air Force Medical Services make a common contribution to the national security. Together we must be able to respond instantly to any combat or contingency requirement. Each of us has a well-defined mission to meet that response. We accept that serious responsibility as part of the national health care community with pride and enthusiasm.

Our Air Force Medical Service has a wartime and peacetime mission. We provide the medical support necessary to achieve maximum wartime readiness and provide a rapid response capability through mobility and flexibility. We promote Air Force combat effectiveness by prevention of disease and injury and provide health care for our members and their families.

In late 1978, a thorough review of our capabilities indicated that we had insufficient resources to accomplish these tasks. We generated specific programs to improve our capability to support combat operations. Medical readiness is our primary concern.

TRI-SERVICE COOPERATION

The Services are coordinating their activities in building for readiness. There has been joint development and procurement of war reserve materiel (WRM), such as hard wall shelters and new generation tentage.

I'm particularly proud of our joint Service readiness training initiatives. The Air Force is an active participant in the Tri-Service Combat Casualty Care Course conducted at Camp Bullis, Texas. We have provided faculty, students, and administrative personnel in support of this outstanding training course. Some 1,251 personnel have been trained to date in this course.

The Medical Red Flag wartime training exercises are still going strong. By the end of this month, the Air Force will have trained over 3,000 medical people in the management of combat casualties by means of the Red Flag exercises. The Army and Navy have provided instructors, equipment, and students. That support has been significant. Other readiness training efforts include a Battlefield

Medicine Course taught at the USAF School of Aerospace Medicine, plus instruction in cardiopulmonary resuscitation and warskills. Under development is a Tri-Service Self-Aid and Buddy Care Program for all Service personnel.

Chemical warfare defense is being addressed vigorously in all Services. There is joint prioritization of research and development (R&D) requirements and then the sharing of that information. Other chemical defense initiatives include the study of techniques for hardening facilities, the training of personnel in the use of protective equipment, and the development of patient decontamination and treatment methods.

A Tri-Service Military Field Medical System Standardization Steering Group has been established to guide the development of standardized field medical systems. The goal is to encourage maximum commonality of medical materiel in the field environment. In addition, a Military Medical Coordinating Group for Materiel Readiness is in being to document the review, coordination, and exchange of information. The objectives are to eliminate duplication of efforts, to determine the degree of equipment commonality for like field functions, and to promote the standardization of medical systems.

The Department of Defense (DOD) has established select task forces that develop lists of common use high volume medical/dental products that will be the items of choice for all WRM programs.

Air Force standard procedure on all items submitted for stocklisting is to inform the other Services of our intent to include the item in our assemblages. We also provide complete descriptive data and proposed specifications.

A review of commonality of medical equipment system for 4th echelon assemblages (outside the combat zone) has been completed. Air Force and Navy programs are 99.5 percent common. Efforts continue to define equipment requirements in terms that will be acceptable to all three Services.

WARTIME THEATER MEDICAL ORGANIZATION

The Air Force has adopted a "four echelons of care concept." The thrust of this plan is to provide effective and efficient medical care to casualties in the combat area; to provide rapid evaluation for definitive treatment as required; and to assure early return of minimally injured combatants. In the event of war, every Air Force member will have a role to play.

The first echelon of care (self-aid and buddy care) is accomplished where the injury occurs. It applies to personnel on or near the individual operating base, and has limited capability such as hemorrhage control, wound protection, and assistance of injured to the next echelon.

The second echelon (emergency care by medics) is sited on or near predesignated operating bases. At this level, triage and initial stabilization is provided. Patients will be evacuated to higher echelons as condition dictates or returned to duty.

Third echelon care is provided in a facility designed to provide immediate surgical care. These facilities will be providing care for patients evacuated from nearby second echelon units. We will concentrate on stabilizing patients, rapidly returning to duty those who are able and evacuating patients who require prolonged care to the next echelon. Patients who can be returned to duty within the combat zone evacuation policy limits will remain in third echelon facilities.

Fourth echelon care is provided in large wartime hospitals located as far to the theater rear as possible. These facilities are sized in increments of 500 beds. Staffed with most specialties, the fourth echelon facilities will be able to provide comprehensive care for wartime casualties. Those who are expected to return to duty within the theater evacuation policy limits will remain at the fourth echelon. Patients who will exceed these limits will be evacuated to the United States.

STAFFING

Sufficient medical manpower has been a continuing concern. I'm pleased to tell you that manning has improved significantly. The special pay bill and the retention program (Project KEEP) contributed to this. All corps are almost fully staffed against authorized strength. There are still significant manpower problems that need resolution. We are short of physicians in key specialties. We must increase physician authorizations to meet mobilization requirements. This is being achieved slowly. The Air Force Medical Service is actively applying methods to refine and procure the correct blend of providers, the proper number of support personnel, and the realistic number to be trained.

The total manpower to support our projected readiness capability has been identified and increased authorizations will be phased with our facilities' growth. From fiscal year 1979 through fiscal year 1982, an additional 2,680 positions (407 physicians, 2,273 other medical personnel) were programmed. Fiscal year 1983 will see another 605 authorizations (25 physicians and 580 other medical personnel).

The following table displays the current status of medical manpower:

MANPOWER STATUS

Corps	Active duty required	Fiscal year 1982 authorized	Mar. 31, 1982, assigned	Authorized versus assigned	Required versus assigned
Medical	5,155	3,692	3,504	−188	−1,651
Dental	1,598	1,590	1,523	−67	−75
Nurse	7,564	4,449	4,384	−65	−3,180
Biomedical sciences	2,243	[2] 2,237	[3] 2,106	−131	−137
Medical service	1,558	1,116	1,099	−17	−459
Enlisted	37,040	25,353	24,871	−482	−12,169
Total	55,158	38,437	37,487	−950	−17,671

[1] Derived from POM development process and PRISM II for MC.
[2] Includes 456 officer PA's.
[3] Includes 421 officer PA's.

The following table depicts the current manpower status of critical wartime specialties:

CRITICAL WARTIME SPECIALTIES

	Active duty required	Fiscal year 1982 authorized [1]	Mar. 31, 1982, assigned [1]	Required versus assigned
Surgery	1,173	286	194	−979
Orthopedics	587	126	54	−533
Urology	139	56	38	−101
OR nurse	1,046	261	274	−772
Nurse anesthetist	973	222	249	−724
Medical service technician	14,316	7,162	7,293	−7,023
Surgical technician	1,292	784	794	−498
Biomed equipment technician	815	502	489	−326
Total	20,341	9,399	9,385	−10,956

[1] Excludes those in training.

Early war mobilization requirements call for 5,155 physicians on active duty. Physicians in excess of current authorizations can be effectively used to provide health care to eligible beneficiaries and subsequently reduce Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) costs.

Physician specialty staffing remains a problem although there was significant improvement during the past year.

Sixty-seven (67) percent of the critical specialty recruiting goal was attained in fiscal year 1981 compared to 26 percent in fiscal year 1980. Those specialties which are currently designated as critical are: surgery (general, colon/rectal, neurological, orthopedic, urologic), obstetrics/gynecology, ophthalmology, otorhinolaryngology, hematology/oncology, rheumatology, and neonatology. The long range outlook is for improved staffing in most critical specialties; however, general surgery, orthopedic surgery, ophthalmology and otorhinolaryngology will remain critical for several years.

WARTIME REQUIREMENTS DETERMINATION

The determination of our wartime requirements is a two-step process. The line of the Air Force determines the projected casualty rates based upon intelligence data (threat analysis), weapons effects, historical data, and other criteria. The Air Force Medical Service then uses a tri-Service data base to compute the bed and physician requirements. The computer model includes the casualty rates, forces at risk, and specifies the requirements for beds in theater and CONUS beds.

Physician requirements by specialty are then determined by diagnostic classi-

fication. Each class contains a predetermined treatment protocol consisting of a series of required tasks, task completion times, and a theater of choice for each task. Service-specific frequencies of occurrence applied to each diagnosis are included. The model applies these diagnostic frequencies to the number of patients admitted and determines the number of patients in each diagnostic class. The model then computes the number of physicians needed in each specialty. At present, this methodology has been applied only to physician specialties. We plan to model other providers of care. Support personnel requirements are currently computed via a ratio method (for example, 7.22 enlisted per physician in CONUS).

RESERVE FORCES

Reserve and Guard manning continues to improve. Overall medical staffing in the Reserve program this past year was 106 percent in the unit program and 87 percent in the individual mobilization augmentee program. Staffing in the Guard was 96 percent.

During this period, physician staffing in the Air Force Reserve was 109 percent in the unit program and 78 percent (of authorized level) in the individual mobilization augmentee program. Physician staffing in the Air National Guard was 81 percent.

There is an Air Force five-year plan to increase the number of Air Force Reserve medical personnel from 5,500 to almost 10,000. The increase means Reserve/Air National Guard will make up 20 percent of the Air Force's total wartime medical team. The plan is part of an overall Department of Defense effort to increase wartime medical capabilities. Some of these Reserve medical personnel will augment full-time Air Force medical staffs on annual training tours and during unit and individual training periods. Since much of it will take place during normal working hours rather than the traditional weekend training periods, it will result in a temporary increase in staffing and available expertise for the hospitals.

The USAF plan for the use of the medical units of the Reserve and Guard will be accomplished in one of two ways. These units, specifically identified as to their mission, will either be deployed overseas or used as backfill for those active duty CONUS medical facilities whose personnel have been deployed. Participants in the Reserve Individual Mobilization Augmentee Program will report, upon mobilization, to the active duty CONUS medical treatment facility to which their manpower spaces have been predesignated. These facilities to which they are predesignated are not necessarily the same facilities in which they perform their monthly Reserve duty.

Currently, Air Force Reserve provides 35 percent of peacetime strategic aeromedical evacuation flying hours utilizing C–141 aircraft. If a major conflict arose today, the Reserve and Guard would constitute 89 percent of the authorized aeromedical evacuation crews.

Our Reserve program through fiscal year 1988 includes plans for two 85-person Medical Service units with aeromedical staging unit missions; ten 23-person mobile aeromedical staging facilities; eight 149-person Medical Service units with aeromedical staging unit missions; six 10-person mobile surgical units; 406 tactical aeromedical evacuation crew members; 198 five-person strategic aeromedical evacuation crews; and other significant additions.

Similar actions to increase medical manning are being taken in the Guard. By October 1991, the medical Guard staffing is expected to nearly double with significant growth in its capabilities and facilities.

Medical training initiatives such as Red Flag include members of the Reserve Forces as well as active duty personnel. The Reserve Forces had a successful training effort called Condor Redoubt 81, and participated in Wounded Warrior and Reforger exercises among others. These exercises gave the Reserve Forces the opportunity for realistic training and demonstrated their readiness and responsiveness.

WAR RESERVE MATERIEL

Air Force medical materiel planners have projected WRM needs to support combat operations. Sufficient dollars to meet those requirements are being programmed. WRM is pre-positioned, insofar as possible, in the theater where it is most likely to be needed. Current casualty estimates applied to anticipated troops at risk require beds far in excess of those available in the European theater.

Through fiscal year 1982, funds were appropriated for 4,240 additional wartime beds and increased mobile surgery capability. The 1983 WRM request includes 2,250 more beds and materiel to implement the program. By the end of fiscal year 1983, our worldwide capability will have been significantly increased.

The Air Force Medical Service already has pre-positioned three 24-bed air transportable hospitals, eight 250-bed aeromedical staging facilities, eight mobile aeromedical staging facilities, nine second echelon units, 100,000 chemical warfare casualty wraps, and 716 shelter first aid kits.

Four (4) 500-bed hospitals are being assembled for shipment to England and Germany. Two facilities in England and one in Germany have been accepted for eventual wartime operational hospitals. Other sites in the United Kingdom and on the Continent are being evaluated for adequacy.

FACILITIES

The ability to meet our readiness needs is hampered by the limitations of our medical treatment facilities. The average age of our medical facilities is 23 years. These old facilities are not designed for increasing outpatient care demands. There is an additional shortage of physician offices, examination rooms, and ancillary support space. The state-of-the-medical-art has changed, requiring more sophisticated equipment and patient testing, and that requires more complex construction.

Following two rather bleak years in our modernization program, the fiscal year 1981 program was funded and included six projects totalling $29 million. The medical construction program for fiscal year 1982 is $126 million and included line safety upgrades at two facilities and modernization and addition to two of our medical centers.

In an effort to intensify the program to upgrade and modernize health care facilities worldwide, we have initiated a program called CHAMP (Clinic and Hospital Accelerated Modernization Program). This is a five-year effort to eliminate serious facility constraints to health care delivery. Our total requirement is $1.7 billion. Our success depends on the support of Congress in providing the funding.

Air Force medical facilities in Europe have suffered austere funding problems as well as additional constraints. In past years, there was a Department of Defense ceiling on the total construction dollars which could be spent in Europe. On-base facilities in Europe with wartime missions require expensive survivability features. Many European installations are extremely small; therefore, space for siting is at a premium. Off-base siting of medical treatment facilities is a long process. Medical facility construction is not eligible for NATO funding. Many of our facilities contain excessive fire/life safety code deficiencies. Our fiscal year 1983 program includes a replacement clinic for RAF Alconbury and an Aeromedical Staging Facility at Landstuhl, Germany. Our outyear construction program includes some 14 projects in Europe.

Recent Department of Defense criteria changes permit an increase in square footage for single and double rooms in medical facilities to accommodate mobilization expansion capacity. The new criteria allows expansion capability to nearly double the constructed capacity. The replacement facility at David Grant USAF Medical Center at Travis AFB, California, will be the first Air Force hospital constructed with the expansion criteria (peacetime 298 beds, expansion capability 555 beds).

Wartime construction planning is exemplified by the hospital planned for Osan Air Base, Korea. It has readiness features included in the design. These include placement of critical services on the lower floor for survivability; berming of lower floor for blast protection; air filtration system; decontamination and other features.

Numerous other actions have been taken to expand our readiness capability. We have developed a five-year warehouse medical construction program (MCP) which will match delivery of WRM hospital's assets. The total program will accommodate our medical WRM storage requirements by the late 1980's.

In addition to the above actions, we have established an off-base siting program for those installations considered to be prime targets when replacement projects are required.

We have also approached the Army and Navy Medical Services with a proposal for sharing of hospital beds and other resources in theater under various scenarios. We have held several tri-Service meetings on his and discussions are continuing.

Medical readiness planning is not restricted to overseas locations. Thirty-eight (38) medical facilities in the CONUS have been assigned contingency expansion missions. The remaining medical facilities will change their missions to provide flight medicine and primary care services to the active duty population. This will free medical personnel for deployment overseas or to one of the selected casualty receiving hospitals. In addition, we are working closely with the Office of the Assistant Secretary of Defense for Health Affairs in implementing the Civilian-Military Contingency Hospital System.

CONCLUSION

The Air Force Medical Service is continually looking for ways to improve its effectiveness and efficiency in accomplishing its mission. Many improvements in readiness over the past few years have been made. Much remains to be done. The attainment of an effective readiness posture is a complex and expensive undertaking. Exquisite timing and precise planning are needed to acquire the manpower additions, adequate support personnel, and the facility modernization and sizing to meet both peacetime and wartime requirements. A significant step toward achieving the above would be the legislative recognition of a peacetime benefit mission. The attendant growth in staffing and facilities would significantly increase our readiness capability for wartime and provide cost-effective health care to military families in peacetime.

I will be happy to answer any questions you may have.

Senator JEPSEN. Admiral Cox?

STATEMENT OF VICE ADM. WILLIAM COX, U.S. NAVY, SURGEON GENERAL

Admiral Cox. Mr. Chairman, I, too, am very pleased to be here today to discuss the aspects and status of medical readiness to support the Marine Corps and the Navy and their contingency operations, and our plans in this area for the future.

As you have already stated, the primary mission of the Navy Medical Department is to be prepared to provide that medical support required by the Navy and Marine Corps personnel in time of war.

In peacetime, our medical department maintains the readiness posture of the active duty force; trains medical personnel for combat missions, and performs operational planning in concert with other naval command components. It also provides support to other authorized beneficiaries within the constraints of manpower and funding. Although support of the peacetime and wartime missions are very often viewed as separate programs, they are in fact inseparable, since common resources are part of both missions.

The Navy and Marine Corps, in order to provide effective in-theater medical support during a contingency, must establish a continum of care from the forward edge of the combat zone back to the continental United States.

After initial lifesaving treatment, patients are transferred rearward to more sophisticated facilities that can initiate or provide definitive care, so that patients can be returned to duty or be prepared for movement out of the combat theater.

This is where there is the great gap in our current capability. We have in the current budget funds for a hospital ship capability for fleet hospitals to meet this need.

The determination of requirements for medical facilities and personnel to provide that necessary wartime support begins with the defense guidance and, as has been stated, using forces at risk and the

expected intensity of combat, a computer-based contingency planning module will tell us the admissions and allow generation of in-theater manpower and manning requirements.

The staffing of the individual in-theater facilities will be based upon variables such as the size, the level of medical sophistication required, and the anticipated intensity of use.

The medical manpower to augment the fleet and Marine Corps units, to expand our stateside and overseas facilities, and to staff our deployable facilities, is met by the use of active-duty personnel, augmented by the Reserves and retired personnel who would be recalled to active duty.

The initial augmentation requirements and manning of early deploying facilities must be met by active duty; Selected Reserve personnel in the next phase; and then Reserves and retired personnel would be called to duty. This will increase the capability, but will still be insufficient to operate stateside facilities at an optimum capacity.

While adequate numbers of personnel will be available to meet in-theater needs, problems do exist in the specialty mix of physicians, as has been alluded to by the Secretary. Currently, our general surgeons, anesthesiologists, and orthopedic surgeons, our primary contingency physicians, are in short supply. While the shortfall of certain specialties is large, the requirement can be reduced in wartime by the use of other specialties with some surgical training—urologists, obstetricians, gynecologists, family practitioners, and others. This will assist in fulfilling the wartime requirement.

In summary, I have a regained enthusiasm about the program. I think the direction is correct, the momentum is building. While our current medical support contingency posture has very serious shortfalls, we have developed a balanced program encompassing personnel, training, afloat hospital ship capability, rapid deployable medical facilities, and fleet hospitals which will meet our needs in the years ahead. Your support of these programs in fiscal 1983 and in the future is crucial to gain a status of medical readiness.

I appreciate the opportunity to discuss our efforts and stand ready to answer your questions.

Senator JEPSEN. Admiral, your prepared statement will be entered in the hearing record.

[The prepared statement of Admiral Cox follows:]

PREPARED STATEMENT OF VICE ADM. J. WILLIAM COX, MEDICAL CORPS, U.S. NAVY, SURGEON GENERAL, DEPARTMENT OF THE NAVY

Mr. Chairman and members of the Subcommittee: I am Vice Admiral J. William Cox, Surgeon General of the Navy. I am very pleased to be here today to discuss the status of medical readiness to support Navy and Marine Corps contingency operations and our plans in this area for the future.

The primary mission of the Navy Medical Department is to be prepared to provide medical support to the Navy and Marine Corps in time of war. Fulfillment of this mission requires maintenance of a balanced force of active duty medical personnel, trained in general medical skills and specific knowledge required for combat support; maintenance of medical skills to rapidly respond to operational requirements; maintenance of a viable reserve program to allow rapid expansion of the medical support element in the event of mobilization; and a support environment in which these personnel can provide care.

In peacetime, the medical department maintains the readiness posture of the active duty forces, trains our medical personnel for their combat mission, and performs operational planning in concert with other naval commands and com-

ponents. It also provides support to other authorized beneficiaries within the constraints of manpower and funding. Although support of peacetime and wartime missions are often viewed as separate programs, they are in fact inseparable, since common resources support both missions.

The Navy-Marine Corps team, in order to provide effective in-theater medical support during a contingency, must establish a continuum of care from the forward edge of the combat zone to the continental United States, essentially establishing a medical organization where none may have existed previously. The concepts for providing support may be best understood by reviewing the sequence of events that must take place.

The highly mobile company corpsmen and battalion aid stations go ashore on Landing Day with the assault force, and provide very limited first-aid and resuscitative care to casualties. Once the assaut force is established ashore, about landing day plus five, the more capable Marine Corps medical companies and hospital companies are phased ashore. In the interim casualties can also be sent to casualty receiving and treatment ships offshore.

The five medical companies with two operating rooms and 60 beds, which are organic to a Marine Amphibious Force, represent the next echelon of care for patients coming from forward battalion aid stations. Medical capability is limited to life-saving surgery and resuscitative care. Available holding capacity permits only very brief holding of patients prior to evacuation rearward.

The hospital company with its six operating rooms and 200 beds also begins landing about day five and provides additional medical capability to accommodate combat "surges" which may exceed medical company capabilities. Patients from the hospital company flow to casualty receiving and treatment ships and to hospital ships and Fleet Hospitals.

The amphibious task force ships provide emergency resuscitative, stabilization, and surgical care that is beyond the physical capacity of marine corps units. The primary mission of ships in the task force, including those designated as casualty receiving ships, is to transport the assault echelon to the amphibious objective area. The casualty receiving ships presently provide the only surgical capability in-theater during the initial force insertion and buildup phase of the landing. After treatment, patients are transferred rearward to the next echelon of care—to more sophisticated facilities that can initiate or provide definitive care so patients can be returned to duty or be prepared for movement out of theater. This is the gap in our current capability. We have in the current budget funds for a hospital ship and fleet hospitals. Hospital ships and Fleet Hospitals are planned to have equivalent acute medical care capabilities to provide in-theater, more sophisticated, medical care. Hospital ships which are more mobile than fleet hospitals, are ready to receive and care for casualties upon their arrival; however, they do require hospitals to which they can transfer patients when they are filled to capacity.

Fleet hospitals are shore-based, modular, transportable hospitals with definitive care capabilities equivalent to hospital ships. They are in 250 and 500 bed sizes and are expected to provide medical support in the communications zone, in countries nearest the communications zone or, under suitable conditions, in the rear of the combat zone itself.

Similarly, existing overseas medical treatment facilities represent "pre-positioned," forward deployed hospitals for support of operating forces along existing lines of communication.

Stateside naval medical centers, clinics, and other support activities are the mobilization base which during wartime receives and cares for casualties evacuated from overseas, provides base medical support for other Navy and DOD activities, and continues to act as a mobilization base for trained medical manpower replacements for forward deployed units.

Clearly, in-theater medical support is much more than just doctrinal organization, it requires medical facilities, people and logistics support, and must be sized to the task at hand. I would now like to discuss how we determine these requirements.

The determination of medical facilities and personnel requirements to provide the necessary wartime support starts with the Defense Guidance, which provides the strategy to meet the threat, the use of forces in combat and, in the area of medical support, specific guidance which directs a set theater evacuation policy, commonality of supply items, pre-positioning of medical support, and direction for expansion of stateside capabilities to provide care in wartime.

Using the forces at risk and the expected intensity of combat, a computer based Medical Contingency Planning Module accepted for use by all three services and now undergoing trial use by unified commands, computes hospital admissions and in-theater manpower and manning requirements. These are developed independently for each scenario, and include the disease and non-battle injury factors. The theater evacuation policy determines where definitive care medical capability is required, and this drives the need for hospital ship and fleet hospital capability. The advantage of longer evacuation policy in theater is the ability to return sick and injured personnel to duty closer to the combat zone, significantly reducing manpower replacement requirements.

Staffing of individual in-theater facilities is based upon variables such as facility size level of medical sophistication, and anticipated intensity of use. The supplies and equipment for the programmed facilities will be prepositioned in containers, and to the maximum extent possible, will be standard among the three services.

The medical manpower to augment the fleet and Marine Corps units, to expand our stateside and overseas facilities, and to staff our deployable facilities is met by use of active duty personnel, the reserves and the retired personnel who would be recalled. The initial augmentation requirements and manning of early deploying facilities must be met by active duty and selected reserve personnel. Later deploying units and augmentation of stateside facilities is planned to utilize the reserves and retired personnel. The first manpower priority is the in-theater requirement, and the stateside base will be reduced to fill these needs. This will force us to operate our facilities at less than the maximum capability, and the Veterans Administration system and civilian facilities will have to absorb the excess patients. As the reserves and retired personnel are called to duty, our capability will increase, but not sufficiently to operate stateside facilities at maximum bed capability. Programmed increases in active duty and reserves will lessen this shortfall.

While adequate numbers of personnel will be available to meet in-theater needs, problems do exist in the specialty mix of physicians. Currently general surgeons, anesthesiologists and orthopedic surgeons, our primary contingency physicians, are in short supply. The Navy Active Duty Deferment Program, which places the Health Professions Scholarship Program graduates into civilian residencies, will improve our future accessions into these specialties. The Incentive Pay and Board Certification Pays in the 1980 Special Pay Act, along with improved ancillary support and equipment, provide incentives for retention of these specialists.

One way to enhance our reserve Medical Corps recruitment would be to allow scholarship graduates, at the discretion of the Secretary of Defense, to fulfill their service commitment through an extended reserve service obligation or a combination of active and reserve service. This would require a legislative change, such a program would have my support.

While the shortfall of surgical specialties is large, the requirement is reduced in wartime by use of other specialties. Urologists, obstetricians, family practitioners, and several other specialties receive surgical training in their residencies, and will assist in fulfilling the wartime requirement.

Also, we are providing all physicians training in wartime medical skills in a tri-service, Combat Casualty Care Course, in San Antonio, Texas. In addition to preparing our surgical specialties for in-theater support, it prepares our non-surgical specialists to provide minor surgery resuscitation, and other life-saving procedures under combat conditions. Two hundred physicians were trained in fiscal year 1981, and an additional four hundred will be trained in this fiscal year.

Navy Hospital Corpsmen have no comparable civilian counterpart. This requirement, until new accessions can be obtained and trained, must be met by active duty and reserves. Since these personnel and other support personnel can significantly increase the productivity of physicians in hospitals during peacetime, we are programming in this budget year and in future years to increase the size of our active force.

In summary, I am very enthusiastic about our programs. While our current medical support contingency posture has serious shortfalls, we have a well developed program encompassing personnel, training, a hospital ship, rapidly deployable medical facilities, and fleet hospitals which will meet our needs in the years ahead. Your support of these programs in FY–83 and in the future is crucial to medical readiness.

Thank you for the opportunity to discuss with you our efforts to provide the best possible medical support to our Navy-Marine Corps team.

I stand ready to answer your questions.

Senator JEPSEN. General Mittemeyer?

STATEMENT OF LT. GEN. B. T. MITTEMEYER, U.S. ARMY, SURGEON GENERAL

General MITTEMEYER. Mr. Chairman, it is also my privilege to be here today.

You have been of great assistance to the Army Medical Department in the past, and I look forward to working with you and the entire committee in the future.

The principal mission of the Army Medical Department is to assure a physically and mentally fit military force and insure a ready reservoir of competent, highly trained health care professionals to support contingencies, mobilization, and combat operations.

The Army Medical Department has made significant progress toward medical readiness and other areas during the last year, with particular emphasis on identifying our hospital bed needs. These are in a program for funding over the next 5 years.

We also have made significant strides in the Professional Filler System. We now have over 3,600 professionals, both physicians and nurses, that are identified for vacancies in the combat scenario. In the area of training we have instituted the combat casualty care course and modified the combat medic course. That has been very positive.

Wartime Army medical requirements are derived from war game simulations based on conflict scenarios, as indicated by Dr. Beary. These simulations estimate among other things, the casualty loads to be anticipated and the number and types of medical units required to treat them. From these unit calculations come then the personnel and material requirements we must satisfy.

Only about one-third of the Army's total medical force is on active duty, with about two-thirds in the Army National Guard and the U.S. Army Reserves.

The ability of these forces to accomplish their mission training and readiness objectives, is absolutely essential to adequate wartime health care delivery.

My goals for the Army Medical Department are intended to assure continuing emphasis in the areas of medical readiness and excellence. First and foremost, I want the Army Medical Department to be prepared for any possible contingency. That necessitates resolution of personnel shortages and imbalances; selected reorganization of some of our combat units—medical combat units—and the modernization and replacement of equipment in both our fixed facilities as well as those we intend to deploy.

I am pleased to report that our active-duty physician shortage, thanks to the HPSP program as well as the Uniformed Services University of Health Sciences, and the physician bonus, is being alleviated as we continue on course with programs and initiatives that promise to resolve this problem.

Active duty physician strength showed sustained improvement with strength at just slightly over 4,900 at the end of fiscal year 1981 and an

increase of 284 over the fiscal year 1980 level. We are projecting a strength of 5,054 in fiscal year 1983 which represents a shortfall of 402 against the Army's peacetime objective of 5,456 by 1987.

Despite this improved physician posture, as was noted by the other Surgeons General as well as the Secretary, individual medical specialty shortages do exist. These shortages primarily, again, in anesthesia, orthopedics, neurosurgeons, general surgery, currently allow me to staff my hospitals at minimum levels—even in the peacetime scenario.

However, these are being addressed through our medical center residency training program as well as the program of deferring certain students for training in civilian training programs.

In the Reserve components, physician strength has begun to improve but major shortages still exist. Since realinement of the Reserve recruiting mission to the Army Surgeon General—which started in July of 1980—and the establishment of a nationwide Reserve recruiting network, specifically to get physicians and professionals from the health care arena in the civil sector, much progress has been made.

In the past 20 months, over 1,800 health care professionals have been brought into the force, and more than 800 of these were physicians. Of that 800, over 150 were former active-duty physicans, which are individuals who know us, and we know them.

Senator JEPSEN. How many?

General MITTEMEYER. There were over 800 physicians out of the 1,800, and of that 800 physicians 150 were doctors who were leaving the Army and were going into the private sector, but decided to join the Reserves. Which not only indicates that they like the medicine that we practice, but they know us and we know them. They know the system, should we ever have to call them back.

Despite these improvements, the shortfall of over 3,500 physicians and 10,000 nurses continues to exist in the Reserve component.

ARMY NURSE CORPS

The Army Nurse Corps active duty strength at the end of fiscal year 1981 was slightly over 3,800 and projected to be slightly under 3,900 by 1983—still approximately 500 short of our eventual active-duty objective for active-duty nurses of 4,430 by 1987.

I might mention that the Army Chief of Staff, in fact the entire Army staff, are most supportive of providing an increased nurse authorization—active duty in uniform—of close to 1,000, which we need desperately.

Similar to the other services, sir, the Army organizes the wartime theater generally into a rear area and forward combat area. We place our mobile tactical medical units in support of combat units in the forward area, while we place larger, less mobile but more broadly capable hospitals in rear areas.

Battle casualties are then linked by ground and air evacuation vehicles from the frontline through combat zone hospitals, to rear area hospitals, and Conus or other large general hospitals through air evacuation.

In order to provide more flexible response to medical care to the combat soldier, we have undertaken an extensive conversion program of our tactical hospital system.

Improvements in capability are needed to support fast moving tactical operations in environments where weather conditions or enemy air activity might restrict the movement of patients from the front to the rear.

The MASH—Mobile Army Surgical Hospital—has been redesigned to be a small, highly mobile unit with capability for emergency surgery on a 24-hour basis. At present, approximately 50 percent of our existing programed combat support hospitals are scheduled for conversion into the MASH concept.

We actually have already begun this MASH conversion. In Fort Bragg this year—in fact last month—we converted our first combat support hospital to a MASH structure. In 1983, we are planning to further convert three active and six of our Reserve component hospitals to such MASH configurations.

The conversion program plus programed activation of additional units will enable us to support each combat division with a larger number of surgical suites and hospital beds. In fact, we are activating an Evac in Europe this year.

We are also continuing to modernize our outdated field medical equipment sets. This is a large task which will require several years of concentrated effort. I believe that these medical sets will provide the necessary supplies and equipment to treat the types of casualties anticipated.

We are placing more emphasis on coordination and interface with the other military services in order to provide standardized deployable medical systems. In order to save time, I will not go into detail on these. I will be happy to provide them for the record. But we are indeed cooperating in many more areas.

STANDARDIZED DEPLOYABLE MEDICAL SYSTEMS

The Army is coordinating and interfacing with the other Military Services in order to achieve the following objectives in standardizing deployable medical systems.

a. Achieve maximum equipment commonality between the military services.

b. Standardize descriptive terminology used by military services in their medical assemblage programs.

c. Provide combat casualty care more efficiently, conserve resources, improve operational flexibility, interoperability and readiness posture.

d. Reduce duplication of efforts in preparing for field medical operation by the military services.

e. Achieve maximum standardization of field medical systems within the military services.

f. Promote and stimulate the coordination, exchange and critical evaluation of information to achieve objectives.

g. Provide a mechanism for the discussion and resolution of differences.

Under the oversight of the Assistant Secretary of Defense (Health Affairs) and the Surgeons General of the Military Departments and Commandant of the Marine Corps the following operational groups have been constituted.

a. Military Field Medical Systems Standardization steering group. Membership consists of one general/flag officer from the medical services of the Army, Navy, Air Force and Marine Corps.

b. Military Medical Coordinating Group for Materiel Readiness. Membership consists of military and civilian specialists representing the medical services of the Army, Navy, Air Force and Marine Corps. Ad Hoc Working Groups have been created to coordinate the following areas. (1) Power Generator and Environmental Control Systems (2) Tactical Shelters, Transport Systems and Site Preparation, and (3) Configuration Development (Fit and Function).

The following have been accomplished:

a. Participated in preparation of DOD Instruction 6430.XX "Department of Defense Field and Other Deployable Medical Systems." This instruction prescribes policy and procedures for standardization and acquisition of identified systems.

b. Exchanged MSC officer between Army and Navy. Army officer assigned to USN Fleet Hospital Support Office and Navy officer is on duty at Combat Development Directorate, Academy of Health Sciences, U.S. Army.

c. Initiated actions to similarly exchange MSC officers between Army and Air Force and Navy and Air Force.

d. Reviewed and coordinated among military medical services:

(1) Basic matrix chart of military field health care facilities for use in the initial functional grouping of facilities based primarily on geographical location within a theater of operations.

(2) Listings of components of field medical assemblages to rapidly identify the items requiring increased efforts to achieve standardization whenever possible.

(3) Specifications and provisioning data on equipment selected for use in deployable medical systems.

(4) Methods of determining components of medical equipment sets including analytical models capable of predicting required types and quantities of materiel.

(5) Detailed charts of power load analysis for each deployable hospital.

(6) Planning data relative to physical layout of equipment within each shelters.

(7) Listings of consultants in each medical specialty to afford direct communication among counterpart personnel.

(8) Tentative concept plans and drawings of Navy 250 and 500 bed combat zone hospitals.

(9) Combat Zone Hospital Equipment Lists developed by Army for 16 functional components.

e. Participated in multi-service, multi-disciplined task force working groups of Defense Medical Materiel Board to identify D-Day Significant Materiel, reduce number of items in DOD supply system and achieve increased standardization.

f. Attended Joint Logistics Commanders Panels on Tactical Shelter Acquisition and Support to assure that medical requirements were met.

The Army's health facility modernization program continues to replace and modernize medical and dental treatment facilities around the world. These new facilities provide us with a setting for state-of-the-art peacetime medical and dental care as well as more effective capabilities for meeting wartime patient loads.

As a part of readiness, we provide training to maintain and improve essential skills. These courses as already has been mentioned, include the combat casualty care course and placing of professionals and paraprofessionals into our fixed treatment facilities and from the fixed treatment facilities into our field operating units.

In response to contingency personnel requirements, the Army Medical Department Professional Officer Filler System has been initiated, and I already alluded to that. We have over 3,600 individuals by name currently identified in the automated system to go into the vacancies that exist when we mobilize.

Finally, I would like to conclude by stating my commitment to the highest quality of health care for our soldiers, both in peace and war. Your help is needed, sir, to maintain the quality of the Army Medical Department and to solve remaining issues by continuing support of budget and manpower programs. As weapons and equipment readiness postures improve, concern for the soldier and his care must be uppermost in our minds.

Thank you, sir. I am happy to answer any questions.

Senator JEPSEN. General, your prepared statement will be inserted in the hearing record at this point.

[The prepared statement of Lieutenant General Mittemeyer follows:]

PREPARED STATEMENT BY LT. GEN. BERNHARD T. MITTEMEYER, THE SURGEON GENERAL, DEPARTMENT OF THE ARMY

Mr. Chairman and Members of the Committee, I am Lieutenant General Bernhard T. Mittemeyer, The Surgeon General, Department of the Army. It is my privilege to be here today. As the new Surgeon General, I would like to state my goals for the Army Medical Department and elicit your support in promoting them as well as discussing some of our accomplishments. You have been of great assistance to the Army Medical Department in the past and I look forward to continue working with you in the future.

INTRODUCTION

The principal mission of the Army Medical Department (AMEDD) is to assure a physically and mentally fit military force and insure a ready reservoir of competent, highly trained health care professionals to support contingencies, mobilization and combat operations. The Army Medical Department has made significant progress towards medical readiness and other areas during the last year. I am pleased to have the opportunity to highlight some of the activities that have occurred over the past year.

My goals for the Army Medical Department are intended to insure the continued emphasis from my predecessor in the areas of medical readiness and clinical excellence. First and foremost, I want the Army Medical Department to be prepared for war. This includes selected reorganization of units, resolution of personnel shortages/imbalances and the modernization and replacement of equipment. Second, I want to continue to enhance the quality and image of Army medicine. This includes improving the quality and professionalism of physicians, pursuing a positive program to improve the images of Army medicine, and insuring that health service facilities meet accreditation and life safety standards. Third, I want to improve the quality and quantity of our professional/ancillary support. Finally, in order to support the goal of a totally fit Army, I will strive to improve health education and assist in developing new physical training standards.

MANNING

Physicians

I am pleased to report that our active duty physician shortage is being alleviated as we continue on course with programs and initiatives that promise to resolve this problem. Active duty physician strength showed sustained improvement with a strength of 4,909 at the end of fiscal year 1981, an increase of 284 over fiscal year 1980 levels. Fiscal year 1983 strength is projected at 5,054, which represents a shortfall of 402 for the Army's peacetime objective of 5,456 physicians. This 5,456 objective is a slight increase (183) over the previous objective of 5,273 and relates to an increase in overall Army force levels now programmed for fiscal year 1987.

In addition to the overall shortage of physicians, individual medical specialty shortages also exist. These shortages are primarily in the surgical specialties—general surgery, orthopedic surgery, neurosurgery, etc.—and are being effectively managed through the Army's Graduate Medical Education (GME) Programs. These programs tailor training to satisfy our medical specialty requirements while at the same time providing a significant recruitment and retention incentive. In fact, the retention rate for first term physicians continues to exceed 30 percent, due primarily to the GME porgrams. Continuation of this trend will provide a very adequate input into the career force. The Army's primary source of physicians continues to be the Health Professions Scholarship Program, with the other major source being provided by volunteers. A small number is also provided by the Uniformed Services University of Health Services (USUHS) program. Although the output from USUHS is not large, it is expected to form a sizable portion of a career stable Medical Corps for the future.

In the Reserve Components, physician strength has begun to improve but major shortages still exist. Since realignment of the reserve recruiting mission in 1979

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and establishment of a nationwide reserve recruiting network, much progress has been made. Reserve Component physician strength improved by 200 from fiscal year 1980 to fiscal year 1981, and by fiscal year 1983 the shortfall is projected to decrease from the current level of 3,915 to 3,653.

With respect to use of civilian physicians, the requirement exists for more flexibility in paying for contract services and contract surgeons. A Department of Defense proposal to amend Title 10 and 37 U.S. Code has been sent to Congress for consideration. The legislation would increase the permissible maximum salary of a contract surgeon to the basic pay of a commissioned officer in the pay grade of 0–6 with over 26 years of service. It would also give the military departments the authority to use personal service contracts for various types of scarce health services when necessary to fulfill the statutory promises of medical care contained in Title 10 of the U.S. Code. The use of civilian consultants by contracting is essential for providing the expertise and services where they are otherwise unavailable to the military.

Nurses

Army Nurse Corps active duty strength at the end of fiscal year 1981 was 3,833 and projected at 3,891 for fiscal year 1983, 539 below their active duty objective of 4,430. Reserve Component nurse strength increased by 943 for a fiscal year 1981 end strength of 5,639 and is projected to be 6,263 for fiscal year 1983. However, a 10,613 shortfall will still exist at that point.

Other

The shortage of Army optometrists and clinical psychologists experienced over the past few years has been largely overcome through the use of the Health Professions Scholarship Program (HPSP). However, the Services were directed to discontinue use of the HPSP program for training any group of health professionals except physicians. Consequently, once the current HPSP enrollment of optometry and clinical psychology students enter active duty, the Army may experience similar shortages again.

Medical support personnel

Adequate levels of support personnel are necessary to insure an efficient and effective health care system since a shortage of support personnel requires physicians to spend time performing non-physician duties. Our levels of medical support personnel are not proportionately increasing as active duty physician strength continues to improve. Although there has been some increase in the numbers of medical support personnel over the past two years, the ratio of support personnel to physicians is declining. We are attempting to resolve this through the programming of additional medical support resources to allow the physicians maximum and gainful occupation of their skills.

Physician assistants

The Army Medical Department is committed to continued utilization of physician assistants. These valuable members of the Army health care team are the most practical, cost effective and best suited health care asset for the provision of first echelon medical care to active duty soldiers in maneuver units and the deployed setting. Most recently the Army Medical Department has begun special training of a small number of experienced physician assistants for use in selected specialty clinics to maximize the efficiency of shortage physician specialists. Under current utilization policies, there are now requirements for 536 physician assistants in the Army Medical Department and we expect to have 445 fully trained by the end of fiscal year 1983.

Veterinarians

As DoD Executive Agent for Veterinary Services, I would like to report on our progress in the consolidation of veterinary functions. The Air Force Veterinary Service was disestablished on 1 April 1980 at which time the Army began to assume phased responsibility for those services formerly provided by the Air Force. We have assumed responsibility for 50 percent of non-Army research authorizations. Air Force military working dog care and animal disease prevention and control programs have been transferred to the Army at 51 Air Force bases. By the beginning of fiscal year 1983, we will have assumed responsibility for all Defense Logistics Agency Activities as well as for 24 Marine Corps and Navy installations both in CONUS and overseas. I can assure you that the consolidation of the Army and Air Force Veterinary Services will be completed by the end of fiscal year 1983 as directed.

The Army developed Food Inspection Technician Warrant Officer program has been implemented. The first increment of warrant officers have been trained and are now on active duty. Another 23 will be trained this year. The remaining 20 will be selected, trained and assigned to duty locations by fiscal year 1983. The warrant officer will be utilized as the supervisor of non-commissioned officers and enlisted personnel involved in food inspection. The veterinary officer will insure food wholesomeness through consultation with those performing food inspections. I must continue to rely upon the knowledge and expertise of military veterinarians, as did my predecessor, in those instances where their unique skills are required to assure the wholesomeness of food as it affects the health of the troops.

TRAINING

Training provides the capability for the Army Medical Department to fulfill its primary mission of being able to support mobilization and combat operations as well as to operate our health care system during peacetime. In addition, training is the key to recruitment and retention, since without good training, a soldier is bored. We have made significant accomplishments in training and plan to refine and expand our program through fiscal year 1983 in order to better support our mission.

Combat casualty care course

The Combat Casualty Care Course is a recent initiative that continues to improve and expand. The purpose of the course is to prepare entry-level military physicians of all services to care for individual combat casualties on the battlefield, as well as to provide them other skills and knowledge necessary to function in a combat environment. In fiscal year 1983, the frequency of this course will increase to 20 from the 10 courses given in fiscal year 1982. There will be 120 students in each class in fiscal year 1983.

I have recently approved the Emergency War Surgery Training Program (EWSTP) to bridge the training shortfall heretofore unfilled by the Combat Casualty Care Course and our Advanced Trauma Life Support Course. This program will allow physicians and physician extenders who have not attended the Combat Casualty Care Course to undergo a short training program on surgical techniques which will enable them to better function under combat or mass casualty situations. The course will be available to physicians, dentists, veterinarians and physician assistants. The program has already been implemented in Europe and is being developed for implementation in other Army Medial Department locations.

Field exercises

Tactical medical units, both active and reserve, continually participate with the Army in field training exercises to enhance their readiness. Units in Germany participate in exercises to improve interoperability among allied forces. In addition, we have continued to emphasize the policy of providing annual field training with local tactical units to our personnel in fixed facilities.

Medical specialist, training

The Army's Division 86 Study demonstrated that enlisted medical specialists require additional combat casualty management skills. Accordingly, I have lengthened the Basic Medical Specialist Course from 6 to 10 weeks to add training in the management of combat trauma and shock. A new advanced course is also being established to provide career level medical specialists with advanced skills in emergency medicine, ambulatory care and medical administration.

Medical centers

Medical centers continue to fulfill an important role in providing medical contingency/mobilization training. This is of particular importance in view of the fact that medical centers are the major source of professional personnel in support of mobilization and special missions. Included in this training is Combat Environment Transition Training and training for the Civilian-Military Contingency Hospital System.

Communication satellites

Our installation hospitals are currently connected through satellite educational television to Brooke Army Medical Center in San Antonio, Texas. This arrangement allows professional education and training to be disseminated on a daily basis. Our long-term plan is to use such networks to provide timely, interactive

medical training. Ultimately, we hope to be able to provide diagnostic and consultative resources directly from the medical facilities to the battlefield.

MODERNIZATION

Conversion/activation of field units

In order to provide a more flexible, responsive medical care system to the combat soldier, we have undertaken an extensive conversion program of our tactical hospital system. Paramount in this program is the introduction of an updated version of the Mobile Army Surgical Hospital (MASH). This unit, re-designed as a small highly mobile hospital, has the capability to provide emergency resuscitative surgery on a continuous 24-hour basis. We envision that the MASH will be deployed in closer proximity to divisional units than has been the hospital support in the past. At the present time approximately 50 percent of the existing and programmed Combat Support Hospitals are scheduled for conversion to the new organization and to the larger 400-bed Evacuation Hospital. We began with a MASH conversion this year at Ft. Bragg, North Carolina. In fiscal year 1983 conversion of 3 Active and 6 Army National Guard and Reserve Combat Support Hospitals to the MASH configuration will be accomplished. The conversion program plus programmed activation of additional units, will enable us to support each combat division with a larger number of surgical suites and hospital beds. These improved capabilities are especially important during fast-moving tactical operations and in environments where weather conditions or enemy air activity restricts the movement of patients far to the rear for lifesaving surgery.

Revisions/updating of medical assemblages

We are continuing to modernize our field medical equipment sets to insure that effective medical care can be provided on the modern battlefield. This is an enormous task which will require several years of concerted effort. When completed, it will provide the necessary supplies and equipment to treat the types of casualties anticipated. These tailored sets will equip all field medical personnel and units—from the frontline medic to hospitals in the rear echelon of a theater of operations. Our greatest concern is the adequate funding of this effort for the next several years.

The Army has discontinued the Medical Unit Self-Contained Transportable (MUST) Program. We did this because some major non-medical equipment, developed over 15 years ago and proved successful in Vietnam, is no longer suitable for modern NATO/Mideast conflict scenarios. All materiel already procured under the MUST program will be fully used, but additional or replacement requirements will be met by improved standard military equipment.

We have placed more emphasis on coordination and interface with the other military services. This has resulted in more effective efforts to standardize field and deployable medical systems. Some of the initiatives already implemented include:

a. Military Field Medical Systems Standardization Steering Group (general/flag rank officers);
b. Military Medical Coordinating Group for Materiel Readiness;
c. Medical participation in Joint Panel on Tactical Shelters;
d. D-Day significant item list for consumption during mobilization.

Facilities program

The Army's Health Facility Modernization Program continues to replace and modernize medical and dental treatment facilities around the world. These new facilities provide us with the ability to improve our medical and dental care as well as adequate space to accommodate increased patient loads and improved capability of meeting wartime requirements. In addition, they aid in the recruitment and retention of critical health care providers. For fiscal year 1983, we have various hospitals and clinics in CONUS, Korea and Germany that are scheduled for modernization and replacement. In accordance with our goal to provide the highest quality of care available, these projects comply with the stringent hospital and professional accreditation and safety requirements as determined by the Joint Commission for Accreditation of Hospitals (JCAH) and other agencies. Currently all CONUS hospitals are accredited by JCAH. Our hospitals in Frankfurt and Landstuhl have received initial one year conditional accreditation and many of our remaining hospitals will undergo initial accreditation surveys this year and next.

Support equipment

Along with the modernization of our facilities is the modernization of the equipment placed in both old and new facilities. Recently, increased funding has improved our ability to keep pace with technological advances and, with the funding of our program through fiscal year 1983, we will continue to do so. We have largely completed the task of modernizing our radiology departments and are applying technology to help restrain cost growth while reducing risk to patients. Most of this technology, such as computerized tomography (CT) scanners and nuclear medicine equipment is expensive to acquire however, the payback more than compensates for this initial expense. These technologies permit faster, safer, and more accurate diagnostic procedures.

To assure the effective, efficient use of resources applied to medical equipment, the Army is revamping the policies and procedures which govern its medical equipment program. These changes focus on better documentation and streamlining of the approval and funding process.

We have also implemented a system to provide more information centrally concerning our Army-wide equipment inventories. This will improve our ability to accurately forecast equipment resource needs. It will also help us monitor the status of medical equipment at each hospital. Improvements to the Automated Medical Department Property Accounting System provide a more effective analysis tool for use by equipment planners.

New systems/standardization

Implementation and automation of two tri-Service, DOD sponsored management information systems, the Uniform Chart of Accounts (UCA) and the Uniform Staffing Methodologies (USM) are well underway in the Army Medical Department. The UCA is in full operation on a partially automated basis, with Army medical treatment facilities supported worldwide from regional locations in Texas, Hawaii, Germany, Japan, and Korea. Worldwide implementation of the USM began on a manual basis in fiscal year 1982 and will be completed by fiscal year 1983. Procurement of equipment and systems to complete automation of the UCA and to provide for USM requirements will begin in fiscal year 1983 and be implemented over a period of about 2 years.

We have made significant progress and improvement in providing automation in support of most Army Medical Department functions. For fiscal years 1982 and 1983 we are planning initiatives in support of medical intelligence, medical logistics, battlefield automation and European medical operations. In addition, we continue to support DOD Tri-Service Medical Information System Programs for the extension of health care/clinical automation systems.

In accordance with the Army's goal for physical fitness we are conducting a program to medically screen individuals over 40 year of age before they participate in physical training. Pilot projects have been conducted at several sites to validate this medical screening process. Testing and analysis of results will continue in order to develop standards for medical screening and physical training.

RESEARCH AND DEVELOPMENT

The number of disease organisms of proven or potential hazard under combat conditions is vast. Production of drugs and vaccines require continuing research since disease organisms change genetically and new disease organisms come to light periodically. In the unstable areas of the world where military conflicts may involve the US, endemic diseases are very likely to produce more casualties than will combat arms. Significant strides have been made in all research areas and we hope to continue a strong research program.

Methods have been developed in laboratory animals to effectively treat certain parasitic diseases, such as leishmaniasis with drugs at much lower doses than are currently required. At currently used doses these drug have toxic side effects in human patients afflicted with these diseases. These new methods, by allowing much lower doses to be used, promise improved treatment of troops in remote, tropical areas where these diseases are endemic.

A nerve agent antidote (2–PAM CL), which complements atropine has been procured and sent to USAREUR. Other new anti-CW agent candidate compounds are being tested for efficacy, CW agent interactions and ultimate military acceptability. The national industrial base for military unique pharmaceuticals is limited and will require significant new resources to meet the pharmaceutical antidote needs in medical defense against CW agents. Plans are being made to

build up the capabilities of these industries to meet military requirements. Items under development include CW patient vital signs monitors, patient wraps, CW hardened litters, improved resuscitation devices and improved patient decontamination techniques. Efforts are being expanded to develop medical equipment for operations in a CW environment, and include the development of multipatient resuscitators for mass CW casualties and chemical hardening of medical supplies.

In other areas techniques are being improved and materiel and equipment developed for prevention, diagnosis and treatment of combat casualties. Treatment of burns and other wounds has been greatly improved with increased understanding of healing processes and functions of various components of body tissues (we can help the body heal itself better). Supportive devices have been developed for jaw injuries which stabilize the jaw, aid in bone healing and are later reabsorbed by the body. Manufacturing approval is being sought from the Bureau of Biologicals for a preservative that has been recently developed which will increase life of stored blood to 49 days in field situations where freezing is not practical. Current methods permit 30–35 days storage under such conditions; the new methods give us a 40 percent increase in the storage time. Stroma free hemoglobin, an oxygen carrying substance, is being modified to improve its release of oxygen and the time it survives in the circulatory system so it can be used as blood substitute. To reduce the logistical problems of providing pyrogen-free, sterile water and oxygen under field conditions, techniques are being developed to generate them on site.

Support was provided for preparation of a Field Manual on "Stress in Continuous Military Operations." Techniques were developed to improve treatment of severe frostbite, heat stress, and missile wounds. Major changes have been recommended in the Army laser safety standards and to improve safety and safeguard the health of workers involved in demilitarization of BZ chemical agent that has been phased out.

Congress directed the Department of Defense to consolidate infectious disease and field maxillofacial injury research. The Army was designated as the lead agency for the purpose of overall fiscal planning and management within these areas. A consolidation plan has been prepared by the Army and has been submitted for comments and coordination to the Air Force and the Navy. The Army Plan proposes to allow the Navy to continue operating the facilities involved in these areas of research under overall management and funding by the Army. Interservice staffing of facilities involved in these areas of research in the Navy, Air Force and in the Army will be strongly encouraged.

MOBILIZATION

We continue to strive for mobilization readiness as a part of our combat service support mission in the event of war. In addition to the current initiatives to restructure and modernize our field medical units as mentioned under the earlier portion on modernization, several other programs are continuing in an effort to improve our mobilization readiness posture.

Civilian-military contingency hospital system

The Civilian-Military Contingency Hospital System (CMCHS), initiated by Department of Defense in 1980, has the objective of supplementing the CONUS military health care system during a large scale conventional conflict overseas. Thus far, thirty-nine thousand beds out of a targeted fifty thousand have been committed. Participation by civilian hospitals is voluntary and presently 480 civilian hospitals have agreed to participate. Coordination is affected at the community level by commanders of designated military medical treatment facilities. The areas where CMCHS is being implemented were selected primarily for their proximity to military hospitals, hospital bed density and the availability of jetports or deep water harbors.

Professional filler system

To respond to contingency personnel requirements, the Army Medical Department Professional Officer Filler System has been initiated to designate professional personnel for deployed and deploying units in the event of mobilization. The system has been successfully implemented during recent training exercises.

Reserve components

Over 70 percent of the total medical force structure is in the Army National Guard and U.S. Army Reserve. The ability of the Reserve Component forces to

accomplish their mission training and readiness objectives is absolutely essential to adequate wartime health care delivery. I am encouraged by improvements in Reserve Component readiness. In order to effect joint coordination and enhance medical readiness at the highest level, a DoD Reserve Component Medical Council was established last year.

Navy support

In joint planning for the Rapid Deployment Force, it was recognized that the Navy would be unable to provide adequate field hospital support to the Marine Forces until late in fiscal year 1983. Therefore, in order to assist the Navy in providing this support, Army field medical and non-medical equipment to support 1,000 beds has been loaned to the Navy.

Medical centers

An integral part of our mobilization plan includes the support provided by the Army Medical Department's medical centers. The role played by these medical centers during actual mobilization is significant. Mobilization planning is primarily directed to meet the requirements associated with a European scenario. Medical centers provide for rapid expansion of the CONUS medical support and training base. As bed requirements expand for returning war casualties, Army medical centers will provide the largest single source—almost one-third—of readily usable hospital beds and expansion capability. Furthermore, the locations of these medical centers puts them near major transportation networks, thus facilitating the rapid movement and reception of patients and medical supplies during wartime. Our medical centers also provide the major source of training for the professional filler personnel required during mobilization. Thus, medical centers are the key to our mobilization planning and requirements.

Dental

Major new initiatives were instituted to improve the dental system's contribution to readiness. Dental manpower resources have been redistributed within the CONUS to insure that comparable levels of care are available at all installations. A policy was established to give priority of care to deployable units and critical personnel.

ESTEEMING

Since the individual is the key to the Army's ability to perform its mission, the Army Medical Department is involved with a variety of programs that improve the working and living environment of the soldiers and their families. These programs reflect the concern of the Army for the individual and result in a greater commitment by the individual to the Army.

Alcohol/drug abuse program

The Army Alcohol and Drug Prevention and Control Program (ADAPCP), under the proponency of the Deputy Chief of Staff for Personnel, is decentralized to major Army commands. I am responsible for providing policy guidance and resource support for the clinical aspects of the program. Recently we opened our first residential treatment facility in CONUS at Fort Bliss, Texas in addition to the facilities we already had in Korea and Europe. These inpatient rehabilitation facilities supplement the 180 ADAPCP outpatient facilities throughout the world and provide programs of 4 to 6 week duration.

Family advocacy program

We have recently been directed by OSD to provide health related services to handicapped children in Europe who are entitled to receive educational instruction from the Department of Defense Dependent Schools. These health related services include medical services for diagnostic and evaluation purposes, occupational therapy, physical therapy and audiology. Preliminary projections are that approximately 300 additional health care providers will be required to accomplish this new mission. Also, increased facilities and equipment will be required.

The ongoing child abuse and neglect program is well integrated, with the military and civilian agencies cooperating and providing mutually acceptable programs. The more recent spouse abuse program is receiving a similar level of attention. In some areas the Army Medical Department is ahead of its civilian counterparts in managing these important areas of protection for children and families. We will continue to improve and modify our program in keeping with society's mandates.

Dental

One aspect that we believe would improve the quality of life would be adequate dental care for dependents of active duty personnel. We are currently exploring initiatives that would provide for additional dental benefits under CHAMPUS and authorize space available dental care for dependents in all military treatment facilities worldwide.

CONCLUSION

I would like to conclude by stating my commitment to the highest quality of health care for the soldier and his family. Since 1974, the Army Medical Department has effectively promoted a program of quality assurance. This includes such programs as peer review, credentialing, patient care audits and risk management. Practitioners are continually assessed on his or her performance, and all persons are given the opportunity for continuing medical education to maintain currency in their field. I am implementing a regulation that will form a panel to assess and monitor health care practitioners that have been identified as manifesting some condition that temporarily impairs their ability to provide reasonable and safe health care. As indicated earlier during my tenure as Surgeon General, one of my goals is to further improve the professionalism and quality of physicians.

Your help is needed to maintain the quality of the Army Medical Department and solve remaining issues by continuing support of budget and manpower programs. The strength of the Army and the Army Medical Department is improving but the actual and potential increases in workload can be more efficiently served by an increase in ancillary support personnel. During the current economic times, the ability to provide adequate numbers with care may not keep pace with the potential workload and the soldier and his family may feel the impact. As weapon and equipment readiness posture improves, concern for soldier welfare must remain uppermost. We should ask and respond to not only "Are they available in numbers?" but also "Are they committed in spirit?".

Mr. Chairman, I thank you for the opportunity to appear before this committee.

Senator JEPSEN. Thank you, General.

I would like to talk about recruiting. Is there a formalized, coordinated recruiting program going on specifically for our practicing doctors, surgeons, and career fields needed by the Department of Defense?

Dr. BEARY. Well, we are attempting through this Reserve Components Council to coordinate it through that mechanism. But really, it is just getting started. Certainly, you put your finger on our key lesion, such as the shortage of surgeons which we need to fulfill our wartime requirement.

When you talk to various commanders in the Reserves, including our own General Holdman from Iowa, they continually express a concern about this matter, worrying that people will be there to support their soldiers when they go into combat.

So, that is something I worry about every day and I hope you all will keep worrying about it along with us and follow up to see if we are making progress.

Senator JEPSEN. How do you recruit for career people in the medical profession? Do you recruit a career doctor to make a career of the service—the Navy, the Air Force, the Army?

Admiral COX. If I may, Mr. Chairman. It begins with recruitment for the Armed Forces health professional scholarship program in medical school, before they become physicians.

Our recruitment continues on from that point. We recruit practicing physicians for vacancies in our own residency or fellowship training programs if they are qualified.

The other endeavor to attract and retain career physicians is supported through the efforts of the Congress, the physician special pay incentives and improvements in the professional environment, both

with ancillary, technical, and scientific personnel, and the facilities in which they work. Retention of career physicians should improve due to these efforts.

So, I would summarize by saying, our process starts all the way back in the premed period, continues through to recruitment of practicing physicians and ends with endeavors to retain these personnel, once they are in.

Senator JEPSEN. If I understand what you are saying, that is a program that has been primarily instigated, initiated, by the services; has it not?

Are there not some doctors in this country that are patriotic all on their own and would find a career in the service attractive? What, specifically, in that area are you doing?

As I have been in the field, I made a point to talk to medical doctors who are also military career doctors. I have asked, "Why are you in the service?" I have been very pleasantly surprised, and I think those folks would be one of the greatest recruiters you ever could use.

I said, "Why are you in the service" and he lit up like a Christmas tree. Because he wants to be, he wants that variety. He wants family life. He wants to travel, which is much better than the 85–90 hour week, the pressure. In a nonmilitary practice you do not see your family and you do the same thing day in and day out.

I cannot repeat very well—and I am not going to attempt to—the talk he gave to me spontaneously. It was spontaneous, it was not something that he had prepared for because he did not expect to see me, and I did not expect to see him; we just happened to come across each other's paths.

Since then, I have asked other doctors and have gotten similar replies—not always. But it seems to me that there are attractive benefits in the services for doctors.

Money, whereas it is important—we are finding in many areas today, as our perspectives and values get reordered and reflected on—is not all that counts, either.

We are finding smaller communities, in my home State, for example, that are having much better results in getting, attracting doctors who move to that area because they want to raise their family not in the "cement jungles" in metropolitan areas but where they can be 10 minutes away from the country, fresh air, and so on.

I would think that for those types of reasons and many others a career in the service would be desirable. I do not mean to be on a soap box here, but that is the type of thing I want to explore and examine.

Do you use career doctors for recruiting? They have tremendous stories to tell, they have really impressed me. General?

General MITTEMEYER. I might just comment, what Admiral Cox said is absolutely correct. I myself was a draftee—I think probably these two gentlemen to my right were also. I stayed in the service because of what I saw and what happened to me.

We have always tried to approach it from the standpoint of, "What can we do for you, young man or lady, that will keep you with us for the next 3 to 5 years" because that is how careers are built. Indeed, for that reason I think one of the key elements, sir, is the importance of our own training centers.

When we speak of the word "training" immediately it is thought of as a place where people just study and learn and are not productive.

On the contrary, in the medical profession—and I say this especially for the medical profession but the same is true for the other professions within the medical departments—training is "hands on" care.

If we can train them, we can usually keep them because they become part of our force; they become part of our family. Whereas, if we have to train them in the civil sector they become used to the medical centers in the civilian community. There is nothing wrong with those medical centers, they are superb. But you see, they become used to Winston-Salem, N.C., or Baton Rouge, La., or wherever the training center may be.

For that reason, our training centers are a critical part of molding our so-called permanent force.

The other big issue is, whether we lose them because of the fact of family pressure. So often that is the deciding factor when the wife says, "I cannot move any more," or when the children—if there is a large family—grow up and one cannot send them to private colleges because of the cost.

If they leave us—and that is one of the main reasons we tend to lose our careerists. Then we would like to do everything we can to retain them at least in the Reserve components.

That is why I made that point. We have lost some fine physicians to the civilian sector and yet, they also serve as good propagandists among the civilian professors. We have several universities where we have a very good relationship now and they are among our best recruiters.

General MYERS. Mr. Chairman, I would like to add some specifics. The health professions scholarship program is a method for the acquisition of physicians. That program is oversubscribed, more applicants than we have space.

The Uniformed Services University is an entry point for career physicians; we have more applications than there are openings in the university.

We recruit from the civilian world very actively with a mailing program that goes out to sometimes extraordinary individuals, including general officers who have been in the medical service, since retired, and they would get a recruiting document in the mail. They always send some clever remarks back to me. The recruiting program has been very successful.

In certain specialty areas we need no more, for example, family practitioners. We cannot take them in the Air Force through the volunteer system. We cannot take any more pediatricians, we are very well staffed. The fact of the matter is, we cannot get the high-income people that we are so badly in need of, surgeons, orthopedists. They are very difficult to recruit. The market just is not out there.

All of these things met with great success, including the medical liaison officers which are now in medical schools who serve as recruiters. The evidence for all of this is, although it may be an apple-and-orange comparison, we were keeping less than 3 percent of our Beary plan physicians. Our calculations for this year, this fiscal year, for continuation of individual physicians who are eligible to separate is in excess of 70 percent.

What we need is head room in authorization to build the force. What we need is facility sizing to accommodate that group.

Senator JEPSEN. If we can take one item at a time now. Can you please tell me what "head room" is?

General MYERS. Yes, sir, the authorizations. We are at the authorized strength. We need to increase the authorization. In our 5-year bill, in the POM, we are looking to those increased authorizations so that we can get the numbers needed for wartime capability and have them on duty at the time they are needed. So, the authorization level has to be increased.

Dr. BEARY. This is the authorization line here, it is the number of slots budgeted. What General Myers is saying, is that the force we have in hand—and he is talking about the Air Force—is getting near or at that budgeted line for the Air Force, and that he needs more authorizations. He needs to reach this line sitting over here.

Senator JEPSEN. This is a reflection of all three military services?

Dr. BEARY. That is all three, sir, for doctors.

Senator JEPSEN. You are saying you have headroom for all three services, on the average, but the Air Force has reached its manpower authorizations.

GENERAL MYERS. No, sir. We are at about 98.5 percent of our current authorizations.

Mr. PRINCIPI. Have you asked for increased authorizations?

General MYERS. Yes.

Mr. PRINCIPI. Have you received them?

General MYERS. We have programed over the next 5 years in our program objective memorandum for the gradual build in numbers that we think are going to be required to be on active duty to meet the first-day needs of a contingency.

Dr. BEARY. As was mentioned, the scholarship program is very popular and at some point it is going to come close to supplying what we need as we look out to where we start to get well with the numbers and specialty mix on active duty.

Well, we then need to think about the Reserve component. We think what would be cost-effective would be to allow scholarship students to serve time in the Reserves. We would increase their obligation, so possibly for each year of medical school support they would have an obligation to spend 4 years in the Reserve when they completed their residency. So, for 4 years of medical school, that would be 16 years of Reserve duty and most would make a career out of it from there if they got 16 of the 20. I think the cost-effectiveness argument would be a very good one.

We would appreciate any support you could give us in that respect.

Senator JEPSEN. General Myers, you said that your overall staff in the Reserve program capacity was 100 percent.

General MYERS. 103 percent in the unit program.

Senator JEPSEN. Is that the headroom you are talking about?

General MYERS. No, sir, I was talking about authorization for active duty. We have been extraordinarily successful in the Reserve program. We have kept many in the Reserves who left active duty. We have watched the Guard build in spectacular fashion, from about 60 percent now to in excess of 85 percent.

Senator JEPSEN. What do you attribute that to?

General MYERS. Well, I would like to think it is the attractiveness of the U.S. Air Force Medical Service. But it is due to a lot of hard work on the part of a lot of people out there. I think there is a commitment on the part of many health care providers, physicians, nurses, and others, a need to serve their country in some way.

It is unfortunate, the same mismatch in specialty is occurring in the Guard and Reserve that we see in the active-duty force.

Senator JEPSEN. Those 106 percent, this good success you have had does not really reflect the specific needs; is that correct?

General MYERS. That is correct. It is a mirror-like image, Mr. Chairman, of what we have in the active-duty force, 9.5 percent manning of current authorizations, wrong match, wrong mix, not enough of the people that we need to meet our contingency requirements.

Any war is a surgically oriented experience from the medical perspective.

Senator JEPSEN. It has not changed much over the years. In 1950 I went to the Arizona National Guard, and our surgeon was a dentist.

General MYERS. I would like to say something at this time about our dental officers, sir. They have responded magnificantly to wartime training. We fully intend to make full use of our dental officers by having them participate actively in the management of casualties. They have risen to that objective.

Senator JEPSEN. I was not making light of that. I am just saying, we did not have quite the right mix back then, either. How about the other services?

Dr. BEARY. Sir, if I could just make a followup to your question. You were mentioning the authorization versus the need. As General Myers mentioned in his testimony, he is programing for another 5,000 people in the Reserve; is that right?

General MYERS. Yes.

Dr. BEARY. So, that is the "head room" he is talking about. He is 100-percent manned relative to what he is authorized right now, but I guess there are another 5,000 physicians he will be recruiting over the next few years. So, that is how the requirement and authorization parts relate to each other.

Senator JEPSEN. Admiral Cox, can we talk about the same general area? How is the Naval Reserve?

Admiral Cox. Yes, sir. In the interest of time, those things that General Myers has said are also true of the Navy Medical Department, with the exception that there has been sufficient fluctuation in the authorized strength of the Naval Reserve at large and the medical component in particular. We are not healthy numerically nor in terms of specialty mix in our Reserve medical component.

General MITTEMEYER. Mr. Chairman, in regard to the Army, we retain approximately 33 percent of our physicians after their initial obligation. If they stay with us after the initial obligation, from then on the retention rate is in the 70-percent area. This is for the active duty medical officers.

In other words, once they stay with us beyond that initial obligation, our chances of holding them are 70 percent. That is a significant improvement as opposed to the retention rate of approximately 2 to 3 percent of the original Beary Plan program.

Another area in reference to the shortages—and this has already been alluded to—because we are short of orthopedists, general surgeons, neurosurgeons, and so forth, they all tend to be overworked because we just do not have enough of them.

In a place like Fort Bragg, where I should have eight general surgeons, I am fortunate if I have four. They tend to be on call a lot and as a result, they work extra hours. So, they feel if they are going to work that hard, then as much as they enjoy their military practice—there is much greater emphasis also on the part of the family—they say, "Dad, why not settle down and get the extra dollars?"

As far as our Reserve components are concerned, of course, we are split between the Guard and the USAR. The National Guard is better off than the USAR. In the Guard, we have almost a 50-percent fill in our position authorizations and are also significantly improving. In nursing, we are over 100 percent in the Guard.

In the USAR, our need is specifically in physician and nurse personnel. We have, as I mentioned, recently made significant progress because we have assumed the recruiting mission and we are really moving in the right direction. But we still have large holes to fill.

Senator JEPSEN. I am told that only 10 percent of our wounded can expect to receive the emergency surgery they will require in war. Is that accurate as things stand right now?

General MITTEMEYER. I jotted that number down. That is hard to believe as things stand now. Of course, it depends upon the type of war we would become involved in. But I certainly would like to get some more information on that.

I think the immediate problem is the immediate shortage. I think after 48 hours, when the war settles down and we have air superiority and we can get air evacuation, that is not going to be the case. It depends upon the type of wounding and that would have a major effect on the morbidity and mortality rate of the wounded soldiers.

Senator JEPSEN. Well, we have some problems; I guess we all agree on that. We also agree that we did not get in this situation overnight. The problems have been some years in the making. None of you can be held personally responsible for the creation of these problems.

However, for the record, I would like to get some basic facts. I would like to know, who is the person responsible for correcting the medical readiness problems? Let me start with the Army Medical Department.

General MITTEMEYER. I suppose I am, sir.

Senator JEPSEN. The Navy Medical Department?

Admiral COX. I am.

Senator JEPSEN. And the Air Force Medical Service?

General MYERS. The same, sir.

Senator JEPSEN. Would you then please provide for the record the organizational structure which assures the medical readiness of each of the four military services if you have not already done so, so we can get that on record?

[The information follows:]

ARMY ORGANIZATIONAL STRUCTURE

General MITTEMEYER. The Deputy Chief of Staff for Operations and Plans has overall Headquarters Department of the Army (HQDA) responsibility for

Army readiness. The Surgeon General, as a member of the Army staff, is the principal advisor to the Deputy Chief of Staff for Operations and Plans with respect to medical readiness issues. Preparedness is pursued along two principal dimensions: unit readiness, and individual readiness.

Each level of command from HQDA down to unit level is responsible for achieving maximum readiness with given resources and accurately assessing and reporting the actual status of units regardless of the resources allocated. Each field medical unit within the total Army force is required to submit a Unit Readiness Report through its major command headquarters to HQDA. These reports define current unit readiness posture in terms of personnel, equipment, and training status.

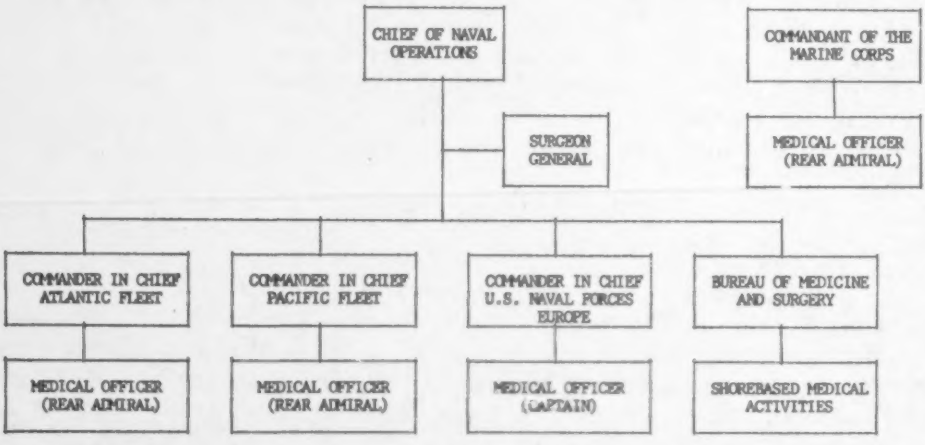
The responsibility for insuring that properly trained individual health professionals and technicians are available to staff Army field medical units lies solely with The Surgeon General. He carries out this responsibility with a health professions recruiting program for both the active and reserve components. He also develops graduate medical education programs designed to insure that physicians with appropriate medical and surgical specialties are available to support the Army in both a peacetime and wartime environment. He insures that all Army Medical Department personnel are individually proficient in their job skills by providing formal training courses and on the job experience. Additionally, all physicians and nurses assigned to fixed medical treatment facilities are required to participate in an annual field training experience. To insure that these health professionals are available to serve in field units, a professional filler system has been developed which is designed to reassign physicians and nurses from fixed medical treatment facilities during periods of increased readiness or mobilization.

Navy Organizational Structure

Admiral Cox. The organizational structure for medical readiness parallels the organizational structure of the Navy. As you are aware, medical provides staff support to the line and a medical officer is on the staff of each major operational command.

I, as the Surgeon General, am the principal advisor to the Chief of Naval Operations for all medical matters. In addition, I am charged with the responsibility to be "responsive" to the Commandant of the Marine Corps. This responsibility is carried out primarily through the Medical Office of the Marine Corps.

As the Chief, Bureau of Medicine and Surgery, I have a staff directly responsible to me to ensure that medical readiness is maintained as the highest priority of the Medical Department. The chart below depicts organizational relationships in the Department of the Navy for medical readiness and planning.


CHIEF OF NAVAL OPERATIONS
COMMANDANT OF THE MARINE CORPS
SURGEON GENERAL
MEDICAL OFFICER (REAR ADMIRAL)
COMMANDER IN CHIEF ATLANTIC FLEET
COMMANDER IN CHIEF PACIFIC FLEET
COMMANDER IN CHIEF U.S. NAVAL FORCES EUROPE
BUREAU OF MEDICINE AND SURGERY
MEDICAL OFFICER (REAR ADMIRAL)
MEDICAL OFFICER (REAR ADMIRAL)
MEDICAL OFFICER (CAPTAIN)
SHOREBASED MEDICAL ACTIVITIES

General Mittemeyer, Congress has been concerned for several years about the Army's hospital shortfalls in Europe. You have touched on that briefly this morning.

The fiscal year 1980 appropriations gave the Army $6.7 million above the budget request to buy four more 1,000-bed general hospitals to pre-position to Europe. Have those been pre-positioned?

General MITTEMEYER. Sir, I will be happy to provide you specifics for the record because of the classification of this subject matter.

However, I can state that in a recent visit to Europe, I was definitely encouraged by what I saw on the ground and what was coming in. We have some shortfalls, sir, to be very frank, specifically as to the markup of these general hospitals. But in general, the program is well on track and the funding has been of extreme assistance to us in providing us with the total number, which is also classified.

[The information follows:]

PRE-POSITIONING PROGRAM

The Army programed to pre-position [deleted] 1,000 bed General Hospitals in Europe. During fiscal year 1980, $6.7 million in funds were received, one year early, to get the program underway. Concurrently, a major revision of the medical assemblage for a 1,000 bed General Hospital was accomplished by the Academy of Health Sciences, U.S. Army, which resulted in significant component changes and increased the total dollar value of the assemblage from $1.5 million to $11.3 million. Therefore, only portions of the total line items for three General Hospitals have been purchased and pre-positioned. Additional resources, OMA and OPA, to cover the revised costs are included in the fiscal year 1983–87 time frame.

Senator JEPSEN. General Myers, does the Air Force intend to preposition and use the deployable hospitals you have requested?

General MYERS. Yes, sir, and we are well on that road, Mr. Chairman. We have acquired two RAF bases in Great Britain where we are stockpiling war reserve materiel for 500-bed hospitals that can be set up within 7 days.

We have acquired through a host-nation support agreement with the Republic of West Germany a facility in Zweibruecken where we will put a 500-bed hospital. We are exploring some rather exciting possibilities at the moment for others.

For fiscal year 1983, we have an impressive array of acquisitions: Four 500-bed hospitals; two 250-bed aeromedical staging units; 18 mobile surgeries; 13 second echelon units; and two 250-bed hospitals in support of the Rapid Deployment Joint Task Force.

Senator JEPSEN. Dr. Beary, have you issued a policy on pre-positioning?

Dr. BEARY. Well, it is contained in the Defense Guidance. Rather than my issuing it, it would be the Secretary of Defense who has issued it. But it is quite clear as to what the policy is on pre-positioning. We can make sure you will have a copy of the pertinent section to clarify that.

Senator JEPSEN. Getting back to the specialty mix problem, what kinds of cross-training programs are now in place in each service to prepare personnel to serve in specialties in wartime shortfalls? Do you have a program that is trying to correct this mix?

General MYERS. I am not quite sure I followed the context of the questions, Mr. Chairman.

Mr. PRINCIPI. You have too many pediatricians and not enough surgeons. What kind of program do you have to cross-train your pediatricians so that they can do surgery in the event of an emergency?

General MYERS. We have three extraordinarily active programs. The first of these is the Tri-Service Combat Casualty Care Course that is conducted at Camp Bollis and all physicians go through that at one time or another. That is wartime training, hands on—a real combat environment.

The medical Red Flag exercises are held in conjunction with—I think, Mr. Principi, you saw one of those first hand where we train under as realistic situations as possible health-care providers to manage battlefield casualties.

Then, each new acquisition, each new physician acquired in the Air Force, has to go through the battlefield medicine course in the School of Aerospace Medicine in San Antonio.

So, now we have trained about 4,000 total and every one in Europe at this moment, every physician in Europe—stationed there in the Air Force—has had battlefield medical training.

Senator JEPSEN. We will have some questions that we would like to submit to you for reply for the record.

Moving along now, how do the Services insure that each of the people who are deployed overseas in wartime know his or her wartime job, how to do it properly?

For example, as Surgeons General, can you assure us that each of you has an effective program in place to insure that everyone who will be ordered deployed has the right shots, uniform, whatever else is needed to permit timely deployment?

I might say for the record before you answer that, we are going to be looking into this area in some detail in the coming months. Do you have now an effective program in place to assure that?

[The information follows:]

MILITARY MEDICAL READINESS—ARMY

Yes, the Army has effective procedures established for the processing of units and individuals in preparation for overseas deployment. The medical processing is but one part of the overall system which is conducted at each Army post or mobilization station.

These procedures are prescribed in an appropriate Army publication and include such personnel and administrative procedures as: personnel screening, medical and dental screening, personnel affairs activities, overseas training and orientation, and packing, marking, and shipping of supplies and equipment. Medical and dental unit personnel routinely assist in health care screening of deploying personnel. This Army prescribed program ensures that all adequate medical, administrative and logistical preparations are accomplished in order to permit timely deployment.

DEPLOYMENT READINESS—NAVY

Admiral Cox. Appropriate training is the key to ensure that medical personnel deployed in wartime will be properly prepared to support the operating forces. This training is equally critical for both officer and enlisted members. Enlisted members receive their initial introduction to combat medicine in hospital corps school. This base further expanded at the Field Medical Service Schools where they not only are trained, but also receive appropriate orientation, including utility uniforms, to the Marine Corps. These skills are actually applied and kept current by assignment to either the operating forces or a Naval Regional Medical Center. The primary training program for officers is the Tri-service Combat Casualty Care Course at San Antonio, Texas. There are numerous other specialty courses which provide training in wartime skills. These include: cold weather medicine, tropical medicine, and chemical and biological defense. In addition, all Medical Department personnel are required to reecive one hour of Fleet Marine Force augmentation training each quarter, with emphasis on field medicine.

In addition to individual training, a number of our medical centers sponsor Medical Mobilization Augmentation Readiness Team units. These integrated units exist to provide rapid response medical support requirements to the operating forces. Each unit is required to receive at least three hours of formalized training per quarter to update and advance their skills, ensuring a high level of operational preparedness. This time requirement is in addition to manditory skill training programs at medical centers. Each year a significant portion of these units receive valuable on-the-job training by supporting the operating forces for exercises or Indian Ocean deployments. All units are required to possess appropriate Marine Corps uniforms and to accomplish and keep current all other personnel actions, i.e., shots, necessary for immediate deployment.

General MYERS. Yes, sir. It is not complete but we feel it is well on the way to being completed. We will have a 250-bed contingency hospital augmentation group that will be attached to our largest medical facility. Each member of that augmentation group, 615 in number, will know precisely what his or her job is, and we hope to proceed with that program and enlarge it.

The training of our people, as I described, in those various programs is very specific. We will build on that as well.

But it is our intent, also, to conduct an exercise which would bring together all of the elements in this war-readiness planning that would, for example, require the placement of a second echelon unit in Europe. The manning of that would come from our fixed facilities in Europe, and we would then take those individuals out of stateside hospitals to augment the staff in Europe and then fill in the CONUS with the Reserve. That is one of the ambitious exercises that we have planned which would make everyone participate in that particular exercise.

Senator JEPSEN. Admiral Cox, is it true the Navy canceled the fiscal year 1982 readiness training for medical personnel that were supposed to report for duty with mobilization augmentation plans?

Admiral Cox. No, sir.

Senator JEPSEN. All right.

Admiral Cox. That was the mobile medical augmentation team that was supposed to go to the field, but the dollars were not there.

Senator JEPSEN. That is the reason they had to cancel it?

Admiral Cox. Yes, sir.

Senator JEPSEN. General Mittemeyer, Congress has supported the Army's request to establish a national training center at Fort Irvin, Calif. We also hear a lot from the services regarding the necessity for training of entire units to develop teamwork and cohesiveness.

We know that the Army hospital has been reopened to support the installation. What is the Army Medical Department doing to take advantage of the realistic medical unit training opportunities offered at Fort Irvin?

General MITTEMEYER. Sir, we have in fact had a large Reserve exercise there known as Wounded Warrior. This was both the guard and the USAR with their component forces. They had a large training program there.

The Active Forces have participated in a real setting by having the medical TOE units, the organizational units of the combat forces that train there, go along with them. For instance, recently when they had that terrible mishap there with the 82d Airborne Division, one of our large evacuation hospitals, the 93d Evac from Fort Leonard Wood, Mo., was there on the ground. They came in very handy.

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But we normally have the organic medical units that are part of either the battalion or the brigade, or the task force, whichever it is that is training there, go along and do realistic training on the ground.

We have not to date used the training center as a training center strictly for just purely active medical force units.

Mr. PRINCIPI. Will you be doing so, General, in the future?

General MITTEMEYER. We certainly should. I must say, there is an advantage and a disadvantage. The disadvantage is that you do not have the actual combat activity on-going. So, it is less realistic. But it will give us a chance to test our own organic medical units.

Senator JEPSEN. This is a "question statement" to start out with. Each of you have indicated that the readiness mission is your first priority. Are we then to assume that any training inadequacies for the wartime mission are due to insufficient funding rather than to a priority lower than that of the peacetime health care delivery system?

[The information follows:]

ARMY—MILITARY MEDICAL READINESS

The Army and the Army Medical Department continuously stress the importance of appropriate training for accomplishment of our wartime mission. Judicious use of training funds and opportunities permit attainment of essential training, however, funding constraints consistently present a challenge to provide adequate, meaningful training for both units and individuals. Commanders at all levels must determine where their limited resources should be allocated in order to obtain the types of training which will be most beneficial to accomplishment of his/her unit's mission.

Admiral COX. Mr. Chairman, I will answer first. The requirements for our medical readiness training have only been recently recognized—by that I mean over the last several years—and have built up very rapidly. For an example, the tri-service C–4 course could only be staffed, and people entered into it at perhaps two or three iterations in the first year.

This year, there will be 20.

General MITTEMEYER. Ten this year.

Admiral COX. Ten this year and 20 next year, with each of us having an input of 40 positions per iteration. So, we will be moving from less than 100 in 1 year, all the way up to 800 persons in that common course down there.

As you well know, when you know something and everybody recognizes that it needs to be done, you cannot just do it overnight. There has to be an orderly acquisition of the resources in order to support it.

I might say from the perspective of the Navy decisionmakers, they too have recognized the need and have been very supportive of our being able to contribute to this endeavor.

We will in very short order be sending a cadre to be trained by the Army to operate the rapidly deployable medical facility, a tent-type interim hospital. The Army will to the training for us. We will be sending the people to get the necessary training. That was a totally unprogramed requirement in the past.

Senator JEPSEN. Is that—you might call it "positive type" of attitude and spirit of cooperation—is that characteristic of all the services now, does everybody have this type of attitude toward this exercise, program goal?

General MITTEMEYER. The biggest problems that we have, sir, indeed—and I am not just placing it on the fiscal aspect of the house—but we have a problem with funding in the sense that not only do we have the important mission of providing peacetime health care with a relatively limited force structure, we are busy from day one on.

But at the same time it would be nice, I have often said, if we had a "medical reforger" where we could actually move entire medical units to Europe for a period of a month or more.

We cannot afford to do it because we would not be able to provide the health care back home. But even at that, when we try to fund training for our paraprofessionals, you know, we talk about having continuing education dollars for physicians. We need them for our nurses; we need them for our administrative staff; we need them for our medics.

Unfortunately, we run out of dollars when it comes to continuing education because much of our continuing education is tied to the TDY dollar and not to the training dollar. We do not get millions and millions and millions for pure training. We could use more.

But indeed, it would be ideal for us to be able to train just medical units. I think General Myers alluded to this thought of having some of our Active Force leave Walter Reed, for instance, and go to Europe and fill in the vacancies that would be created by mobilization, and have a Reserve unit move into Walter Reed and take over the mission.

Or to have the 804th Hospital Center in the New England area move into England and pre-position themselves on those RAF sites where they would literally take over the mission of staffing those 1,000-bed general hospitals. But that is going to require "big bucks."

But we can still at least program it and plan on it.

Mr. PRINCIPI. Again, General, is it a fair statement to say that as a practical matter today your wartime readiness, wartime mission, is subordinate to your peacetime mission?

General MITTEMEYER. I think it is part of the same. Every day that a surgeon operates, whether he be at Fort Bliss, Tex., or in Washington, D.C., or out on the west coast, he is literally doing active training for what he would be doing—with a slight change, depending on the type of wounding.

So, it is really an integral part. Our medics, our X-ray techs, our lab techs, our internists, they are all basically doing the same with a slight change in the direction to which they would be providing their primary thrust.

Senator JEPSEN. Would each of you please provide for the record a statement of how much funding you requested for wartime skills training in fiscal year 1983, and how much is included in the budget?

[The information follows:]

WARTIME TRAINING BUDGET

I have $3.1 million in the budget specifically identified for wartime skills training in fiscal year 1983. This is both the amount that I requested and the amount that is included in the budget. This amount is specifically identified for such courses as the Combat Casualty Care Course, Medical Effects of Nuclear Weapons and the Chemical Care Casualty Management Course. There is other wartime training that is scheduled but these costs are not specifically identified in the Army Medical Department budget. These are a multitude of field training exercises and other training that are a part of various courses whose costs are not separately identified. There are also training exercises in which our field medical units participate with and are funded by other Army major commands.

FUNDING FOR WARTIME SKILLS TRAINING—NAVY

Admiral Cox. The Navy Medical Department requested and received, during the Navy review process, a $640,000 increase for Operational Training—training military medical personnel in wartime skills. The total in the fiscal year 1983 budget for this type of training is $1,924,000.

MEDICAL WARTIME SKILLS TRAINING—AIR FORCE

General MYERS. Approximately $2.437 million has been included and requested for medical wartime skills training in the fiscal year 1983 President's Budget Submission.

Just briefly, Admiral Cox, in our manpower personnel and training problems, even if they are all solved, as things stand, our medical services will still be unable to provide support without facilities, supplies, and equipment.

I am pleased to hear that field hospitals in the fiscal year 1983 budget are going to be standardized. It will take a long time to get that ball rolling but I am happy to see progress being made.

All of you have our support and we are going to continue to monitor that progress very closely.

Admiral Cox, if the RDJTF is deployed this year, how would you support the Marines?

Admiral Cox. This year the RDJTF deployment would be supported by ordering the personnel necessary to man the Rapidly Deployable Medical Facility. This is a composite of borrowed materiel from the Army, presently in San Francisco, that is intended to be pre-positioned in the potential theater.

Senator JEPSEN. When will the $25 million we gave the Marine Corps this year provide support capability?

Admiral Cox. When will it?

Senator JEPSEN. Yes.

Admiral Cox. By summer of 1983.

Senator JEPSEN. Are you responsible for the concept of the deployment of those hospitals?

Admiral Cox. The deployment? I am a participant, but I am not responsible for the concept of deployment, because that is a line-operated command function. The Warfare and Defense Planning Staffs, the CNO, and the Commandant of the Marine Corps, would say where they are going to need it and under what circumstances they would need it; whether it was an invited landing; whether it was an opposed assault; or whether they anticipated "x" amount of days of advanced warning.

While we are consultant participants as staff officers, the final determination on that is the decision of the theater commander-in-chief.

Senator JEPSEN. I understand what you said, but I would please like to have provided for the record a description of how the Navy's operational doctrine for the medical support of the Marine Corps is developed, and clearly indicate who is to be held singularly responsible for seeing that this mission is accomplished.

Admiral Cox. Yes, sir.

[The information follows:]

OPERATIONAL DOCTRINE

Admiral Cox. Operational doctrine is the responsibility of the Service Chiefs. The medical portion of the operational doctrine is developed within the operational commands with the advice of the staff medical officer. As the senior staff medical advisor in the Department of the Navy, it is my responsibility to review the operational doctrine and ensure that the planning to carry out the medical mission is complete.

Senator JEPSEN. Gentlemen, I want to thank you for being with us today. I would entertain any closing comments. We will submit some additional questions for the record.

We are intending to have some additional hearings. I will be visiting with you, Admiral, and invite your advice and counsel with regard of how we can help develop before 1986 this boat hospital facility for this country. That is for all of our benefit.

Much has been done in the past year to remedy the many serious problems which now make it somewhat impossible for us to give our Armed Forces even the minimally adequate medical support in wartime. We have made some progress. I gather—and it is very refreshing and very encouraging, gentlemen, to hear from the four of you here this morning—that we are not going to rest on our laurels, that there is a lot more to be done. You all know that.

This subcommittee, I assure you, will continue to have a great interest and will be very supportive of your actions because we do intend to make sure that this progress continues. It has, as was said earlier, been neglected way too long.

Do you have any summary, closing comments, Dr. Beary? You have been acting now for how long?

Dr. BEARY. Since last September. I joined the Department last May.

Senator JEPSEN. I hope that will be corrected?

Dr. BEARY. I would emphasize again that the successes of the Reserve programs are key to what kind of record we will achieve if our forces are mobilized. I think priority has to be placed there, and I am encouraged by the specific efforts that General Mittemeyer mentioned in his office in terms of his direct personal attention, the good access his Reserve commander has to him, and the various other initiatives he described.

So, from where I look at it, the viewpoint of all three services, and what do we have to support the forces of the United States, the Reserves have to get a lot of attention in this decade.

Thank you.

General MYERS. Thank you, Mr. Chairman.

I spoke in my statement of the need for executive timing and planning to provide the needed support for our forces that are committed to combat. There is an intense need in my perception to work a very coordinated program.

Let me explain more fully for just a moment. As we acquire the number of physicians needed at the first of a, "come as you are" war, those same physicians must have a place to gainfully work.

Our facilities are currently not sized to accommodate that number. There is a support "tail" for those people that would include corpsmen, nurses, civilian clerks, secretaries, and so on.

I feel the medical personnel needed to meet combat requirements can be effectively utilized in peacetime through proper sizing of our

facilities legitimizing the care for the majority of eligible beneficiaries. We calculate that this would result in many CHAMPUS patients returning to the more cost-effective military health care system.

Thank you.

Senator JEPSEN. Admiral Cox?

Admiral Cox. Mr. Chairman, it has indeed been a pleasure to appear before this subcommittee today. I wish only to reassure you, there is no higher priority correcting the deficiencies we have in contingency medical support.

Senator JEPSEN. General Mittemeyer?

General MITTEMEYER. Mr. Chairman, my sentiments are the same. Thank you very much for allowing me to be here this morning.

Senator JEPSEN. Thank you.

Credible requirements are an absolute necessity. So, your collective effort to develop an improved, consistent method of determining requirements for health personnel, materiel, and facilities is absolutely vital if we are going to have success in any future budget requests which we want to help with.

We find when we cannot have some consistency or rely on statements because they are inconsistent, then I guess we probably will not achieve what both of us would like to see done. Your efforts to improve training in wartime skills and to enhance Reserve recruiting and retention are also a move in the right direction. They appear to be solid first steps in a journey of a thousand miles.

What more can and should be done to integrate Reserve and active duty health services personnel to a true total force which can do its job in both peace and war.

Now, if the medical Reserves are well managed and Reservists found their training to be satisfying, as you have just indicated, General, the Air Reserve—you are working on that diligently—I think it would help resolve our recruiting retention problems.

Given the present Reserve shortfalls, I am surprised that nearly a year has passed and the Secretary of Defense has apparently done nothing to implement the recommendations of the GAO to evaluate precontracting with civilians to meet medical early need components. Is that an accurate observation?

Dr. BEARY. Well, we do have a request pending with the Comptroller to budget that item. We intend to follow that up.

Senator JEPSEN. Dr. Beary, you can count on providing a progress report on all the recommendations of the GAO report in a future hearing. We do intend to pursue that.

This subcommittee is not convinced that even if you had all the manpower you asked for, and if you had all your personnel trained to do their job in wartime, that your field hospitals allowed them to work.

Your progress toward stadardization is commendable, but the way you plan to pre-position, store and maintain your hospitals is equally important. At the moment it seems to us that the Army has a real problem in this area, and the other services have potential to develop a similar problem as they acquire hospitals. It must be corrected or prevented and we in this subcommittee will do everything we can to be supportive in this area.

A CMCHS is a logical, a sound approach to overcoming a major shortfall in both facilities and providers in Conus. The subcommittee

endorses its further development and trusts that the civilian health care community will continue to support CMCHS.

It appears to me, however, that the real heart of the CMCHS development lies in the local commands and their exercise and agreements. So, we will expect to hear more from the Surgeons General about the local plans and exercises in future hearings.

Finally, in the broadest view, gentlemen, each of you has indicated to us that readiness is the primary reason for your organizations' existence. Were it not for the readiness mission, we could extend some sort of health insurance to members of the Armed Forces to solve a lot of our problems.

What you say, however, and what we see in the readiness area are, in some cases, two different things. You need to take a close look at your priorities and see if they are really as you would attempt to have us believe.

I do not, for instance, deny that your peacetime health-care delivery system mission is important and necessary. But it is not the main reason for the existence of the military medical services. Its wartime and peacetime missions are at least of equal importance and deserve the same pursuit of excellence in mission accomplishment.

So, before your next hearing I would like to see evidence that your total force personnel management, including training and assignment policies, and your wartime facilities and materiel management, are complementary and that they reflect as first priority excellence in the wartime support of our Armed Forces.

To that end we will do everything that we can to support and to continue to educate. I think that is a joint mission that we can work together on, educating not only each other but our colleagues—mine in the Senate and yours in other areas—the Government, the administration, GAO, some of the hierarchy in the Defense Department, Dr. Beary.

As you can tell—and I will repeat it just one more time—we are dead serious in this committee about correcting some of this 10, 15—whatever it is—certainly 10-year neglect.

It is just, frankly, unacceptable for me, whether the figure be 1 out of 10 or whatever it may be, to know that we are asking our young men and women who serve voluntarily in our Armed Forces, being the front-line persons, for 48, 72, 15 hours or 15 days—to go off to war without the knowledge that they are going to receive and have first class and updated medical care and equipment and everything else that they need.

I am speaking to a "choir in church". I know that and I appreciate that. I want you to know that I know that. I just want to assure you that we are not going to tolerate any failure to meet an obligation to do all we can for these folks who at some time may have to fall in battle defending our country.

So, to that end we are going to pursue this. Let us know what you need.

Thank you very much.

General MYERS. Thank you, sir.

Senator JEPSEN. I have additional questions which I will submit to each of you to be answered for the hearing record.

[The questions, with answers supplied, follow:]

QUESTIONS SUBMITTED BY SENATOR ROGER W. JEPSEN

WARTIME MEDICAL REQUIREMENTS

Senator JEPSEN. The subject of requirements is extremely important. Indeed, the wartime requirements determined by the Services are the very foundation of the military health services system.

The need for consistency among the Services in determining resource requirements was well-documented in the 1979 Defense Resource Management Study. It was further underscored in the DoD Wartime Medical Posture Study sent to Congress in 1980. Military medical resource requirements should be determined using a wartime workload-based methodology common to all the Services. In 1981, a GAO Report, "Will There Be Enough Trained Medical Personnel in Case of War?", again cited the need. It went on to describe a tri-Service effort to develop common planning factors and a new DoD model to make personnel requirements consistent. The GAO report said DoD expected to have the model available in 1981, and a 1981 report of the Surveys and Investigations Staff of the House Appropriations Committee stated that the Services had "voluntarily" agreed to use the model to generate the fiscal year 1983 manpower and facility needs.

Have the Services, OSD, and JCS formally approved the "Voluntarily" agreed upon model described in last year's GAO and S&I reports? If not, why not? When will formal approval be accomplished?

ARMY

Answer. No, the Army has not formally approved the Tri-service Medical Planning Module (MPM) described in the GAO report "Will There Be Enough Trained Medical Personnel In Case of War?" A critical element of the model is the Tri-service medical data base. This has been developed and was approved by the Army on 29 July 1981. The MPM has been forwarded to the various Commanders-in-Chief (CINCS) for staff review. Responses are to be returned to the Office of the Joint Chiefs of Staff at the end of August 1982. Upon receipt of the responses, Office of the Joint Chiefs of Staff will formally staff the MPM for approval.

NAVY

Admiral Cox. The Medical Planning Module of the Joint Operational Planning System III has received "working approval" by the Navy for testing and evaluation by the Commanders-in-Chief of unified and specified commands and their support components. Full service approval is pending the Commanders-in-Chief or user evaluation.

Other modeling efforts principally occurring at the Army's Academy of Health Sciences, Fort Sam Houston, Texas, are intended to refine the Services' projected medical requirements and capabilities estimates. Navy medical personnel presently assigned to the Academy are actively working toward assuring these models will accommodate modifications unique to the Navy/Marine Corps mission.

AIR FORCE

General MYERS. The Joint Operations Planning System Medical Planning Module has not yet been formally approved. Technical delays were experienced in transporting the model to the Unified and Specified Commands for field testing, user orientation, and validation by the medical planning staffs at the Commands. However, the Air Force has tentatively approved the model pending receipt and review of specific comments and recommendations from the principal field users of the model. We expect that formal approval will occur in late summer 1982.

FISCAL YEAR 1983 REQUIREMENTS

Senator JEPSEN. Were fiscal year 1983 requirements for manpower, materiel, and facilities determined by the "Voluntarily" agreed upon model? If not, please provide for the record exactly how each Service's requirements were generated.

ARMY

ANSWER. No, the Army's fiscal year 1983 requirements for manpower, materiel and facilities were not based upon the Medical Planning Module (MPM). The requirements were determined using an annual Army study entitled Total Army Analysis (TAA). The purpose of TAA is to establish time-phased non-divisional tactical support unit requirements and adjust the force to within affordability

levels. The process is based upon a computer warfight simulation between friendly and enemy forces that are expected to exist at the end of the program period. As a result of the warfight, the computer model develops casualty data for the population at risk. This data, in conjunction with Army approved allocation rules, is used by the computer model to determine the numbers and types of all medical units required to support the force. Each type unit is designed with standard numbers of personnel and equipment required to fulfill the unit's mission. All of the units, with their personnel and equipment, are aggregated to form the total requirement. Representatives of the Army staff and major commands review the computer-generated force requirements to assure compliance with Defense and Army Guidance. Adjustments are made to insure that compliance guidelines are met and the force is structured within the overall programming constraints.

NAVY

Admiral Cox. The 1983 resource requirements were developed using the fiscal year 1983 Defense Guidance, which provides the scenarios and forces to be committed. Based on these factors, and using the methodology of the jointly developed model, the in-theater bed and staffing requirements were developed. These requirements, plus the augmentation requirements for Navy and Marine Corps units and the requirements to operate facilities in the Continental United States at their expanded bed capacity, total to the wartime requirement.

AIR FORCE

General Myers. The Medical Planning Module was not available for use in determining the Air Force's fiscal year 1983 requirements. However, an Air Force-developed computer-based methodology similar to this model in concept and in actual results was employed for fiscal year 1983 as it had been in the past. Specifically, it computes requirements based on the application of Air Force-approved casualty rates to the theater population at risk and considers such factors as average length of stay and the evacuation policy for the theater in question. Physician requirements were calculated, to the extent possible, through use of the Tri-Service theater care diagnostic classification data base. Manpower requirements in other disciplines were derived through tabulation of specific numbers of personnel deploying to the theaters of operations and through application of various support ratios for CONUS facilities in wartime.

MILITARY MEDICAL READINESS

Senator Jepsen. Does each of the Services determine the total force health services manpower requirements based on the wartime mission?

ARMY

Answer. Yes, the Army bases its health services manpower requirements on a wartime mission.

NAVY

Admiral Cox. Total force health services manpower requirements are based on the wartime mission of Navy and Marine Corps.

AIR FORCE

General Myers. Yes, the Air Force determines its requirements for Total Force health services manpower based on its wartime mission.

REQUIREMENT DETERMINATION

Senator Jepsen. Once you have the total force health services manpower requirement, how does each Service decide how much of the requirement will be met by the active duty force and how much must be met by the Reserves? What criteria govern the split?

ARMY

Answer. The Army's decision on how much of their total force requirement is to be satisfied by Active and Reserve Component forces is dependent on the Force Structure Allowance which constrains both Active and Reserve Component Manpower authorizations to a specific level. The Army Medical Department, in concert with the remainder of the Army, competes for these constrained resources following established guidelines. Our priority for fill with Active Component

forces is the medical support required for a multi-division force outside North Atlantic Treaty Organization (NATO), plus the D-DAY force within NATO and sufficient staffing for our Conus facilities which would allow transition to a mobilization standing. The remainder of the requirements would then be filled by the Reserve Component.

NAVY

Admiral Cox. The Defense Guidance defines the contingency scenarios for which medical support may be required. The scenarios define the mobilization and deployment time frames, and thus the point at which medical support will be required for the forces at risk. Navy and Marine Corps units which deploy prior to reserve mobilization is the criterion governing the requirement for active duty medical personnel. Additional active duty health service personnel are needed to continue basic operations of facilities in the Continental United States (Conus). Reserve personnel are used to augment active duty personnel in deploying units and in Conus facilities as the mobilization protocol makes them available.

AIR FORCE

General Myers. The split between the active duty force and the Reserves is governed by the necessity to deploy medical forces early to meet the peak theater medical requirements. We consider which types of units, and in what quantities, must be immediately available to satisfy early mobilization needs. These early mobilization requirements will be met, for the most part, by the active duty force. Requirements for theater deployments which occur later in the conflict as well as for Conus sustaining operations will be met by the Reserves.

PERCENTAGE OF RESERVES

Senator Jepsen. What percentage of the total force health services requirements is met by the Reserves in each Service?

ARMY

Answer. The Reserve Components account for 66 percent of the total Army Health Services manpower requirements.

NAVY

Admiral Cox. Of the total requirement, 18.5 percent is met by the Selected Reserve; an additional 26.5 percent will be met by other reserve categories, retired personnel, and volunteers.

AIR FORCE

General Myers. The Air Reserve Forces meet 29 percent of the Air Force's Total Force health services requirement.

RESERVE HEALTH SERVICES MANNING PERCENTAGE

Senator Jepsen. What is the current Health Services Manning percentage in the Army Reserve Component?

ARMY

Answer. The current Health Services Manning percentages within the Reserve Component are as follows:

Corps:	[2] Percent fill
ANC	69
DC	94
MC	36
MSC	[1]105
AMSC	60
VC	79
Physician assistant	61
Subtotal	69
Enlisted	81
Total	78

[1] MSC overstrength is used to fill authorized MC and ANC positions.
[2] Percent of fill is measured against authorized positions.

NAVY

Admiral Cox. The Selected Reserve portion of the Naval Reserve Medical Department is manned at 83.5 percent overall. By Corps it is as follows:

	Percent
Medical Corps	82.0
Dental Corps	89.8
Nurse Corps	88.9
Medical Service Corps	91.0
Hospital Corpsman	81.4
Dental Technicans	92.3

AIR FORCE

General MYERS. As of 31 March 1982, the health services manning percentages was 96.57 percent in the Air National Guard and 101.3 percent in the Air Force Reserve.

RESERVE REQUIREMENTS

Senator JEPSEN. How accurately do the current Reserve health services authorization levels reflect the respective requirements?

ARMY

ANSWER. The Reserve Component Army Medical Department units are currently authorized 97 percent of their total manpower requirements.

NAVY

Admiral Cox. Current authorization levels for Selected Reserve reflect approximately 58 percent of requirements.

AIR FORCE

General MYERS. The wartime requirements of both the Air National Guard and the Air Force Reserve health services will undergo tremendous increases in the next decade. The ultimate effect will be a doubling of the overall medical manpower of the Air Reserve components. This increase in requirements and the resultant increase in authorizations will be manned as they come on line. Although overall medical manning in the ANG/USAFR is excellent, there are selective critical shortfalls in several specialty areas like Surgeons and Orthopedic Surgeons, for example, that lead to an imbalance in the specialty mix.

RESERVE MEDICAL TRAINING

Senator JEPSEN. Describe briefly how the Reserve Training mission is integrated with the active force health care delivery and preparedness missions in peacetime. Do you feel that you are making the best possible use of the Total Force assets at your disposal?

ARMY

ANSWER. The Army Medical Department cannot fulfill its wartime mission without the reserve component force structure. Consequently, every possible effort is being made to incorporate reserve component units and individuals into the total Army Medical Department system for providing medical care in both peace and wartime environments.

The Total Force concept has been enhanced by the Army's Capstone program. This program organizes active and reserve component units into force packages designed to facilitate joint training and war planning. Several AMEDD reserve and active component units are involved in this program.

Members of Army Reserve Component medical troop program units routinely perform inactive duty training in health care facilities of the active component; Veterans Administration and other federal facilities; affiliated civilian hospitals/clinics; community action projects and at semi-active Army installations. During Annual Training periods, reserve component units and individuals are integrated, as much as possible, into active Army medical treatment facilities of the U.S. Army Health Services Command.

Because reserve component units make up the majority of the Army Medical Department total force, they have participated in many major field training exercises. Exercise Wounded Warrior, conducted during May 1981, integrated both reserve and active units in a major medical field training exercise. Again, in April 1982, during Exercise Bold Eagle, conducted at the Army's National Training Center, Reserve Component field medical units participated with their active counterparts.

It is estimated that five to six percent of all dental treatment procedures reported by the U.S. Army Health Services Command are performed by Reserve Component personnel while serving in a training status.

During fiscal year 1981, in excess of 10,000 Reserve Component personnel were trained along side active duty personnel at the Academy of Health Sciences, U.S. Army. The number to be integrated into formal training courses in fiscal year 1982 will surpass 12,000 students. Training received by Reserve Component personnel is identical to that provided their active duty counterparts. Reserve Component participation in Active Army Professional Post Graduate Short Course Programs is expected to increase from 200 participants in fiscal year 1981 to approximately 1,000 students in fiscal year 1983.

NAVY

Admiral Cox. The medical reserve training is integrated into the active health care delivery system in several ways. The unit training at the Reserve Centers is based upon a training manual developed by our active duty training command at Bethesda. The Weekend Away Training is performed as a unit at Reserve Centers or Navy Hospitals and Medical Centers; and individual two-week training is accomplished in Navy hospitals and Medical Centers.

I believe that, in the past, full use of the Selected Reserves was not made. In order to improve this situation, I have directed each medical center to designate a Reserve Liaison Officer to improve relationships between the reserve units assigned to each medical center. This will result in improved utilization and training. In addition, the implementation of the Temporary Active Duty Program, which is used to fill in for temporary active duty specialty shortfalls, has proven to be a most beneficial program.

AIR FORCE

ANSWER. The majority of Reserve and Guard medical personnel train at active duty medical treatment facilities during their two-week annual training tour to familiarize themselves with CONUS medical operations. Reserve and Guard personnel receive the same training as that provided to our active duty forces. Training includes, but is not limited to:

a. Unit disaster team training;
b. Medical facility operations during conflict;
c. Primary first aid;
d. Nuclear, biological, and chemical warfare; and
e. Management of combat casualties.

I feel that we are making excellent use of our total force resources in the Air Force Medical Service.

CLINICAL CROSS-TRAINING PROGRAMS

Senator JEPSEN. With regard to the specialty mix problem, what clinical cross-training programs are now in place in each service to prepare personnel in specialties which show a wartime surplus to serve in specialties with wartime shortfalls?

ARMY

ANSWER. The Army Medical Department (AMEDD) provides a number of cross training programs to prepare physicians and other providers to function effectively in a wartime environment to make up shortfalls in certain specialties. The Combat Casualty Care Course (C4) is an intensive 8-day course, conducted on 10 occasions this year (20 next year) and each course accommodates an input of 40 Army physicians, plus physicians from other services. All Army interns, brigade and battalion surgeons are scheduled to attend this course. Our goal is for all physicians to attend C4. Courses in Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS) are offered both in CONUS and overseas and provide certification to physicians by the respective American

colleges. Our goal is to have all physicians ATLS trained. All physician short course training (approximately 35 courses) emphasizes training in combat specific casualty treatment. Overseas short courses and symposiums also emphasize wartime casualty management. Locally sponsored courses in Emergency Medical Training are oriented toward combat specific case management.

Inherent in many Graduate Medical Education (GME) programs are clinical rotations to prepare the subspecialists to function, in an emergency situation, in other than his or her trained specialty. For example, an OB/GYN Surgeon is qualified and would be called upon to assist (perform) in selected surgical cases. The American Certifying (Specialty) Boards have lengthened certain training programs (orthopaedics) requiring additional general surgery which enable them to assist during initial stages of wartime scenarios. Other surgical subspecialists such as ENT (Otolaryngologists), Urologists and Plastic Surgeons can similarly assist. Clinical rotations in other GME programs such as Pediatirics prepare these physicians to function in infectious disease casualty management. Psychiatry training programs as well as research endeavors are aimed at preparing for the Combat Psychiatry treatment anticipated. Students at the Uniformed Services University of the Health Sciences (USUHS) are required to successfully complete two courses, one in Emergency War Surgery as well as another course which is equivalent to the C4 Course. Much of the didactic portion of the USUHS curriculum is directed at emphasizing combat casualty treatment.

Other programs cross-train physician extenders as well. Physician Assistants (PA) are receiving specialty training in Orthopaedics and Emergency Medicine, with ultimate planned utilization in these subspecialty areas. Many PA providers are working in Emergency Treatment Centers and would be so utilized in wartime situations. We are planning to expand these extender training programs into general surgery and other subspecialties.

The AMEDD also participates in clinical cross training programs offered by other uniformed services such as the Red Flag program conducted by the Air Force. The requirement for annual fie'd training by physicians prepares and enables them to utilize field medical equipment and serve as filler personnel during initial expansion into certain wartime shortages. A pool of manpower for some shortage specialties exists in the students currently in AMEDD GME programs. Those students beyond a certain point in their training would be called upon to function in shortage specialties.

NAVY

Admiral Cox. The Navy has made significant strides in developing programs to prepare all physicians for these wartime roles. We have instituted a program to provide for one year of transitional Graduate Medical Education for new physicians, prior to an operational tour, which maximizes clincal cross-training. To Combat Casualty Care Course, which will train 400 Navy physicians this year and 640 next year along with 160 other prioritized medical personnel, provides field orientation and certification by the American College of Surgeons in Advanced Trauma Life Support.

These basic medical skills, as well as those skills developed through medical and surgical specialty training, have wide use in mobilization.

Additional training is provided in Tropical Theater and Infectious Disease, Cold Weather Medicine, Chemical, Biological and Radiological warfare defense, and Mobile Medical Augmentation Readiness Team training.

AIR FORCE

General MYERS. As you know, the Air Force developed the Medical Red Flag Exercises and the Battlefield Medicine Course and has participated in the Tri-Service Combat Casualty Care Course to help rectify the specialty mix problem. In addition, the Air Force Dental Corps has developed a comprehensive, three-phase training program to permit our dentists to perform duties in the surgical environment under wartime conditions. The Air Force Nurse Corps also has been participating in the Combat Casualty Care Course and has developed a Battlefield Nursing Course to expand its members' skills to better handle wartime casualties. We recently asked the RAND Corporation to conduct a study of our physician workforce and analyze the joint contributions physicians in various specialties can make toward the peacetime and readiness missions. The model RAND will develop and allow us to assess the maximum wartime capabilities of alternative peacetime forces, including those whose capabilities are en-

hanced through (1) additional training in wartime skills and (2) redesign of wartime task assignments. Given any desired balance between peacetime services offered in Air Force medical facilities and readiness to deliver wartime care, the model will be able to select, from a number of alternatives, an appropriate physician workforce, training curriculum, and assignment pattern. We are excited about the prospects for greatly improving our physician workforce design as a result of the innovative study.

PRECONTRACTING CIVILIAN HEALTH PERSONNEL

Senator JEPSEN. Dr. Beary, the GAO report I alluded to earlier had some specific recommendations to the Secretary of Defense. In his testimony to the Defense Subcommittee of the House Appropriations Committee last year, Dr. Moxley said your office was evaluating the GAO recommendation regarding precontracting with civilian health personnel to meet early requirements in CONUS. What is the status of that effort?

Dr. BEARY. Health Affairs has requested $2.5 million from the ASD (Comptroller) to develop and test a system for precontracting civilian medical personnel for use in CONUS military medical facilities. If the test is successful, we would expand it to 100 facilities at a cost of $25 million. Our expected completion date is 31 March 1983.

WARTIME HEALTH PERSONNEL CAPABILITIES

Senator JEPSEN. Would you, Dr. Beary, and each of the Surgeons General please provide for the record a statement of what has been done to implement the other recommendations in the GAO report?

Dr. BEARY. The GAO report contained 11 other recommendations. These are listed below followed by the current status of each.

Recommendation: Develop consistent estimates of medical manpower based on constrained (by other medical resources) and unconstrained requirements.

Status: Standard methodologies for computing manpower requirements have been developed and their use directed in DoD Instruction 1100.19, "Wartime Manpower Program Policies and Procedures (Warmaps)," due to be published by 30 June 1982. The methodologies, the Joint Operations Planning System (JOPS) Medical Planning Module for unconstrained requirements and the HOSPITALS model for constrained needs are presently usable and available for Service use. ECD: 30 June 1982.

Recommendation: Develop a consistent and systematic method to estimate yield rates for Reserve Component medical personnel after mobilization.

Status: A Request for Proposal has been submitted and bids received to contract, develop, and evaluate methods to estimate these yields. ECD: 30 June 1984.

Recommendation: The Services periodically report their requirements estimates to DoD for developing overall medical mobilization plans.

Status: The Services provide these requirements to DoD in the Program Objectives Memorandums (POMs) and Warmaps submission. ECD: Complete.

Recommendation: Identify and implement specific initiatives to recruit and retain nurses while continuing initiatives for physicians.

Status: An Ad Hoc Working Group, established in April 1981, continues its efforts to identify and eliminate problems and prepare solutions to provide for a satisfactory level of nurses. Initiatives to recruit and retain physicians continue. ECD: 30 September 1983.

Recommendation: Develop plans to meet DOD's early post-mobilization requirements for surgeons and other military-unique specialties.

Status: Program to address broad spectrum of initiatives has been started. Initiatives include making reserve training requirements more flexible, a contract with the American Medical Association to develop a plan to identify and acquire critically short physicians voluntarily early in a mobilization and the establishment of a Reserve liaison officer program at medical schools. ECD: 30 June 1983.

Recommendation: Make prearrangements for inter-Service assignments.

Status: Subsequent to policy formulation by the Ad Hoc Group for Medical Specialty Substitution and Cross-Service Utilization, a DOD instruction is to be published providing procedural guidance to the Services. ECD: 30 September 1983.

Recommendation: Make arrangements to use Public Health Service officers made available by HHS.

Status: The DOD Master Mobilization Plan contains provision for this. ECD: Complete.

Recommendation: Establish firm criteria for the frequency and duration of in-hospital training to be given to field unit personnel.

Status: A Director of Medical Readiness Training has been added to the Health Affairs staff to address the recommendations to the Army and ensure their implementation. ECD: 30 September 1983.

Recommendation: Determine the extent to which tri-service courses should be expanded to provide such training to personnel not now eligible.

Status: Tri-Service courses are now being evaluated to make such a determination. Periodic review of course content, policy, and validation of learning will be accomplished to ensure skill-level achievement. ECD: 30 September 1983.

Recommendation: Evaluate the applicability of earlier recommendations for the Army for the other Services.

Status: The evaluation is taking place and the recommendations implemented in the Navy and Air Force where indicated. ECD: 30 September 1982.

Recommendation: Develop legislative proposal for a post-mobilization draft of medical personnel.

Status: Proposed legislation for a health care occupations draft has been developed and is currently being staffed through appropriate agencies. The proposal should be submitted to Congress in January 1983. ECD: 30 January 1983.

ARMY

Answer. The GAO report makes specific recommendations on how to improve the level of clinical and combat related skills among Army medical personnel by increasing and re-structuring training programs, and by providing guidance to commanders giving increased priority to medical readiness. Members of the Army Medical Department (AMEDD) must function simultaneously in two separate environments—the daily patients care environment which support eligible health care beneficiaries and the field medical support environment which supports combat units through such activities as maintenance of equipment and training.

Commander U.S. Army Forces Command (Forscom), commands all Active component AMEDD field units and is responsible for the supervision of training. The Commander USA Health Services Command (HSC) commands all active component AMEDD fixed medical activities within his area of responsibility. A new Memorandum of Understanding (MOU) between Commander Forscom and Commander HSC has been drafted and is expected to be approved at an early date. The MOU establishes guidelines for fixed Medical Treatment Facilities to provide training for field unit medical personnel. It establishes frequency and duration of in-hospital training. The Commander Forscom has directed that each medical field unit commander send assigned medical personnel to the local military hospital for training. The Commander HSC has directed the commanders of medical treatment facilities to provide and monitor realistic clinical training for all medical field unit personnel.

NAVY

Admiral Cox. The Navy, both independently and in conjunction with the Department of Defense, has taken significant steps to improve our medical manpower readiness during the past year. Medical planning to develop requirements has been refined and the results are reported through the programming system to the Department of Defense. The Medical Mobilization Steering Group, under the Assistant Secretary of Defense for Health Affairs, and other high level groups have increased the awareness of the problems and specific actions are underway.

In fiscal year 1983, there is a sizable increase in physicians and nurses and other support personnel, and more are programmed for the future. Retention of physicians and nurses has improved; we have budgeted for a sizable increase in readiness training; we have budgeted for a hospital ship and fleet hospitals, and we are prepositioning a one thousand bed facility in the Pacific.

In summary, I believe that the majority of recommendations made in the General Accounting Office report are being addressed by the Department of Defense, and a major improvement in medical readiness is occurring in all the Services.

AIR FORCE

General Myers. The Air Force has taken steps to assure that appropriation training is provided to all categories of military medical personnel. On 11 May

1981 we published Air Force Regulation 160–25, Medical Readiness Planning. Chapter 7 of that regulation details the readiness training required for medical personnel. In addition to normal skill progression training, all medical personnel must receive annual training in cardiopulmonary resuscitation, basic first aid, and chemical warfare defense. Providers of care receive 19 hours of training in the care of specific types of battle casualties. Additional training concentrates on the individuals role in disaster casualty management.

Medical Red Flag exercises are used to provide hands on training in the management of combat casualties, as well as lectures from prominent physicians with battlefield experience.

The Air Force routinely assigns five Combat Casualty Care Course (C4) billets to dentists and four to nurses for each class. In combat situations, it is anticipated that non-physicians will be subject to the same environment as the physician and, at times, may be the only individual available to perform the type of life saving procedure taught in the Advanced Trauma Life Support portion of C4. All other portions of C4 are equally applicable to physicians and non-physicians and are so taught without differentiation.

It should be noted that C4 will be expanded to a maximum of 20 classes per year beginning fiscal year 1983. The Air Force has 40 spaces per class for a total of 800 spaces per year. The Batttlefield Medicine Course trains non-surgical physicians in skills applicable to second echelon levels of care. The Battlefield Nursing Course will provide nurses with advanced casualty care procedures oriented to second echelon. In the future, now accessions to the Air Force Medical Service will initially receive basic medical readiness training at the School of Health Care Sciences, Sheppard Air Force Base, Texas.

The Air Force Medical Service does not have personnel permanently assigned to field units. Personnel are assigned full time to a medical treatment facility with an additional duty to a mobile field hospital (Air Transportable Hospital—ATH). These individuals exercise the ATH at least twice a year in addition to training requirements associated with all medical personnel.

MILITARY MEDICAL READINESS

Senator JEPSEN. General Mittemeyer, have you had a chance to visit Europe or Korea since you became Surgeon General?

ANSWER. I have visited both Europe and Korea since becoming the Surgeon General. I visited Europe during January and February of this year, and Korea in April 1982.

Senator JEPSEN. General Mittemeyer, did you visit Burtonwood and Pirmasens? How about Sagami Depot?

ANSWER. While in Europe in January and February 1982, I had the opportunity to visit Burtonwood, but not Pirmasens. While in the Far East in April 1982, I was briefed on the operation, but I did not physically visit the Sagami Depot.

Senator JEPSEN. Gen. Mittemeyer, what is your personal impression of the Army Medical Departments' prepositioning program? Would the prepositioned hospitals be usable when and where they are needed?

ANSWER. My personal impression of the Army Medical Department's prepositioning program is that it will succeed if the Army's funding initiatives are fully supported by the DOD and Congress. As an intricate and necessary part of a thoroughly planned and balanced Army prepositioning program, the Army Medical Department has participated fully in development of programs to ensure that there are sufficient medical units in the force, along with required funding initiatives to purchase and store prepositioned medical equipment, which will permit us to maintain at least a 15-day evacuation policy in the early days of a war. Given the necessary support for these vital planning and programming initiatives, and a reasonable level of Host Nation Support, the prepositioned hospitals will be usable when and where they are needed.

Senator JEPSEN. Gen. Mittemeyer, why should we fund more hospitals to be piled up where they cannot be used?

ANSWER. All Army hospitals requested in the programmed force would be fully utilized in the event of war. Based on a recent capability analysis, the Army can support no more than forty percent of its wartime theater evacuation requirements at present, primarily because of force structure and equipment shortfalls. In order to avoid a very high level of morbidity and mortality in the theater of operations, it is imperative that the minimum essential level of hospitals requested in the Army program be funded. The Army has no intention of piling up hospitals where they cannot be used.

CIVILIAN-MILITARY CONTINGENCY HOSPITAL SYSTEM

Senator JEPSEN. In looking at the shortfalls faced by DOD in caring for wartime casualties in CONUS, we are very pleased that DOD, the civilian health care community and now the VA are working together to meet the requirements. We are disappointed in the controversy over the Civilian-Military Contingency Hospital System which has been unfairly instigated by anti-nuclear protestors. No one on this Subcommittee is in favor of a nuclear war. While we have that position in common with those who oppose the CMCHS, we can still see a very definite need for the CMCHS to support conventional warfare scenarios. We endorse your planning effort as an excellent example of how DOD can effectively meet its requirements without a multi-billion dollar price tag.

Who will be responsible for CMCHS operations in wartime?

Dr. BEARY. The DOD Directive establishing the CMCHS stipulates that the Secretary of Defense will activate the program in time of war or national emergency, and will monitor the activated system. This Directive further stipulates that the Secretaries of the Military Departments will be responsible for the operation and management of their respective portions of the CMCHS. The commanding officers of each military coordinating hospital are responsible for the operation of the system within their CMCHS areas.

Senator JEPSEN. It sounds as though the Reserves would have a logical role to play in CMCHS. Have they been given one?

Dr. BEARY. The DOD Reserve Components Medical Council recently recommended a program to use Reserve personnel in coordinating teams for the CMCHS program. The Military Services concurred in the proposal, and a policy has been promulgated. This policy authorized the establishment of a Reserve Coordinating Team at each CMCHS coordinating medical facility. This team will function as the primary staff to assist the military hospital commanders in the development of the local program, execution of the annual exercise, and program operation if activated. This program will ensure that key trained personnel are immediately available to operate the system if it is activated.

Senator JEPSEN. Dr. Beary, what happens after a civilian hospital agrees to participate in the CMCHS?

Dr. BEARY. A memorandum of understanding is signed by both the participating civilian hospital and the coordinating military medical facility. Through this memorandum of understanding the Department of Defense and the civilian hospital mutually agree to jointly plan for the admission, treatment, hospitalization, and discharge of active duty patients under the CMCHS. This agreement further provides that the civilian hospital will participate in an annual exercise of the CMCHS plan. Once the majority of civilian hospitals in an area have made the decision on participation, the development of the area operational plan is initiated. The military coordinating hospital commander is tasked with the development of the plan and the coordination of an annual exercise in conjunction with the participating hospitals and local disaster planners.

CIVILIAN MILITARY CONTINGENCY HOSPITAL SYSTEM

Question. Do each of you Surgeons General support the CMCHS?

ARMY

Answer. The CMCHS program has my complete and unqualified support. I want to state very emphatically that I think the CMCHS program is a vital and viable part of the Army Medical Department's total mobilization capability.

NAVY

Admiral Cox. Yes, I believe the program significantly improves our stateside contingency capability. At the local level, Civilian Military Contingency Hospital System implementation involves three phases: (1) recruiting hospitals; (2) building a capability with the hospitals recruited, i.e., developing an operational plan; and (3) system testing/maintenance, i.e., exercising the system and training of personnel.

AIR FORCE

General MYERS. Yes.

Senator JEPSEN. How are your hospitals doing in the development of the local plans which make the system work?

ARMY

ANSWER. Progress in the development of local Army CMCHS plans is good. Plans are developed after maximum likely participation from the local civilian community has been reached, usually six to twelve months after initial program implementation meetings have been conducted. Six Army coordinating hospitals have reached this maximum likely local growth. Four of these coordinating hospitals have completed draft plans. The remaining two are working on their plans at present. Eight other Army hospitals are still in the process of fully developing civilian hospital participation in their respective areas. Plan preparation will begin in those areas as soon as all participating civilian hospitals have been identified.

NAVY

Admiral COX. The Navy is implementing the Civilian Military Contingency Hospital System at twelve Naval Regional Medical Centers; four have completely finished the recruiting phase; six have developed initial operational plans; and the remaining activities are either still recruiting hospitals or developing their initial plans. I feel the Navy is making substantive progress.

AIR FORCE

General MYERS. Local plans are now being prepared and are expected to be completed this year in all Air Force CMCHS areas.

Senator JEPSEN. How has the CMCHS affected the development of your [Army's] plans for wartime support in CONUS?

ARMY

ANSWER. The CMCHS has affected Army CONUS wartime support planning in that it has been included with mobilization planning which existed prior to the CMCHS program. The resulting aggregate capability will provide a more responsive health care delivery system for patients returning from an overseas theater of operations.

NAVY

Admiral COX. The Civilian Military Contingency Hospital System is being integrated into our mobilization planning, although much work remains to be done in the areas of administration, communications, transportation, training, and medical regulation before it is a real capability.

AIR FORCE

General MYERS. The CMCHS and Air Force CONUS wartime medical support plans are complementary. Thirty-eight Air Force medical facilities in CONUS have the mission of providing care to returning wartime casualties. Fourteen of these hospitals also serve as coordinating hospitals for CMCHS. The added capability of casualty treatment provided by civilian hospitals participating in CMCHS is an extension of the system for wartime medical support in CONUS.

Senator JEPSEN. Have you requested any additional manpower authorizations or funding for exercise of the CMCHS? (Why not?)

ARMY

ANSWER. No. The system is currently being implemented within existing resources. As local system implementation plans are finalized manpower and exercise funding requirements will be identified and requested by the appropriate means.

NAVY

Admiral COX. Additional resources have not been requested to exercise the Civilian Military Contingency Hospital System in the 1983 budget. The program is generally in the recruiting phase and has not reached a general maturity

level to warrant a system wide test of the Civilian Military Contingency Hospital System.

AIR FORCE

General MYERS. Yes. One officer and one enlisted position will be added at each of the 14 Air Force CMCHS hospitals in fiscal year 1984 for planning and exercise of CMCHS together with related wartime missions.

In addition to the active duty manpower, the Air Force has been asked by the Acting Assistant Secretary of Defense for Health Affairs to establish a Reserve Coordinating Team at each CMCHS coordinating hospital. We fully support this concept and intend to request associated Air Force Reserve manpower authorizations in fiscal year 1985.

Additional operations and maintenance funds, which may be needed to conduct CMCHS exercises, have not been defined. A joint service exercise in the Washington, D.C., area is planned for September 1982. The purpose of this exercise is to evaluate an exercise protocol and to determine the cost of conducting these exercises.

Senator JEPSEN. The hearing is adjourned.

[Whereupon, at 10:55 a.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

MEDICAL READINESS OF THE ARMED SERVICES

WEDNESDAY, MAY 26, 1982

U.S. SENATE,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, D.C.

The subcommittee met in open session at 2:06 p.m., in room 224, Russell Senate Office Building, Senator Roger W. Jepsen, chairman, presiding.

Present: Senators Jepsen, Nunn, and Exon.

Staff present: Anthony J. Principi, counsel; Paul C. Besozzi, minority counsel; Michael B. Donley, Richard D. Finn, David S. Lyles, professional staff members; Ralph O. White, research assistant, and Kimberly A. Manning, staff assistant.

Also present: Jon Etherton, assistant to Senator Jepsen; Greg Pallas, assistant to Senator Exon.

OPENING STATEMENT BY SENATOR ROGER W. JEPSEN, CHAIRMAN

Senator JEPSEN. The Subcommittee on Manpower and Personnel convenes today to receive testimony on the subject of military health systems management, including quality assurance.

I am especially pleased to welcome before the subcommittee my distinguished colleague, Senator Dan Inouye, a strong proponent of adequate medical care for military personnel, their dependents, and retirees.

We also have Dr. John Beary, Acting Assistant Secretary of Defense for Health Affairs; Lt. Gen. Paul Myers, the Surgeon General of the U.S. Air Force; Vice Adm. J. William Cox, the Surgeon General of the U.S. Navy, and Lt. Gen. Bernard Mittemeyer, the Surgeon General of the U.S. Army.

We are holding these hearings because the President has requested $6.7 billion for health care for fiscal year 1983, and I am certain that each of you understands the accountability of the Congress to the taxpayers for every dollar, especially in these austere times.

We must be absolutely certain that the Department of Defense is wisely and efficiently managing its resources to achieve the most effective health care system we can provide for the 9 million Americans who serve. We are in no way questioning the needs for your services, only how the services exercise the responsibility to manage these resources.

A number of questions concerning the military health system management have been raised in numerous recent studies of your system. I am sure that you are aware of these reports but, for the record, I am referring to the 1975 report of the military health care study; the 1979

defense resource management study; the 1979 GAO report called "Military Medicine is in Trouble, Complete Reassessment Needed," and the 1981 report of a survey of the investigation staff of the House Appropriations Committee on DOD medical programs.

All your written statements will be included in the record. In the interest of time and our wishes to pursue some specific issues, I would ask the representatives from the military services and the Department of Defense here to make your oral testimony as brief as you can.

Now, without any further delay I welcome Senator Inouye. I thank you for taking time to appear here today and testify on what is a very key area in our defense posture and one that we are going to spend quite a bit of time and effort in not only shoring up, but seeing if we can do a better job.

So, Senator Inouye, you may proceed as you wish.

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR, STATE OF HAWAII

Senator INOUYE. Thank you very much, Mr. Chairman.

I thank you for this opportunity to participate in this hearing.

The Department of Defense CHAMPUS program currently serves approximately 7.9 million dependents of active duty, retired, and deceased personnel. Three years ago, as you indicated, Mr. Chairman, the CHAMPUS program was in serious disarray. Since that time, I believe substantial progress has been made in developing a well-administered program of which we can justifiably be quite proud.

Today, however, CHAMPUS faces significant problems in addressing the ever-escalating cost of health care. For example, in fiscal 1978, the CHAMPUS budget was $556 million; in fiscal year 1982, the CHAMPUS budget will be approximately $1 billion.

Hospital costs in particular are a major problem. During this year alone the average cost per hospital admission has increased by a little over 25 percent, in spite of aggressive peer review efforts imposed by CHAMPUS.

Although we now appear to have alleviated the physician shortage within the service itself, the CHAMPUS workload continues to rise by 10 to 20 percent, while the caseload performed on military bases has not increased proportionately.

Mr. Chairman, I feel that the time has come for your committee to seriously consider providing the Department of Defense with significant administrative flexibility to conduct studies and demonstrations in the way health care can be delivered so that CHAMPUS can aggressively address the ever-escalating health care cost problem.

During our deliberations on the fiscal years 1981 and 1982 appropriations bills I had included provisions to allow CHAMPUS to test out alternative delivery models such as health maintenance organizations and to explore the specifics of a dental plan.

What I propose today, Mr. Chairman, is essentially how our Nation's private insurance companies make reasoned decisions regarding their plans. These companies develop benefit packages which they think their consumers will want, and then test their ideas out in the real world. They see what actually happens and then they make modifications. My proposal, which is embodied in S. 2104, will allow

CHAMPUS the same broad flexibility. Mr. Chairman, most respectfully, I believe that it cannot help but save funds in the long run.

Second, I would urge your committee to remove the current legislative restrictions on the specifics of the CHAMPUS medical package and allow the Department to develop and modify the type of health care programs that it feels it can reasonably afford.

I strongly feel that high-quality health care for CHAMPUS beneficiaries is very much in our national security interest. It is the men and the women of our defense that actually protect our Nation. If they or their loved ones are not in the best of health, we are seriously jeopardizing our national security.

Health benefits are not only just an incidental enticement for enlistment, I believe they are a fundamental investment for our entire Nation. If your committee would be willing to consider this approach on an incremental basis, I would urge that you begin by deleting the current legislative restrictions on routine eye care.

Currently, we have a situation where those individuals on bases can receive this care free, paying only for the corrective lenses obtained, while those using CHAMPUS off base must pay from about $30 to $50 for an eye examination. I am certain that all of us would agree that vision care is very important and that our Nation's optometrists and ophthalmologists will not "rip off" the system—I am convinced that they are truly dedicated professionals. The Department estimates that the cost of this proposal would be $22.6 million in fiscal year 1983.

My third recommendation is that the committee insure that those who reach the age of eligibility for medicare not automatically lose their CHAMPUS entitlement. I understand that most of the leading health benefit plans in the private sector, and those especially for Federal employees, make their plan a "second payor" to medicare. I urge that this subcommittee do likewise for the 400,000 individuals involved. I understand that this will mean an additional cost of approximately $60 million.

Finally, Mr. Chairman, I would like to commend you, for your efforts to insure that the position of Assistant Secretary for Health Affairs will be filled on a timely basis. I am pleased to advise you that I fully share your enthusiasm for Dr. John Beary. He has done a good job to date and we have something special in him, he knows something about the Pacific. So, we urge that he be given the most expeditious handling on this point.

I thank you very much, Mr. Chairman, again, for this opportunity to participate in these hearings.

Senator JEPSEN. Thank you, Senator. We have been meeting quite regularly here lately and I check with Dr. Beary every time he appears here to see if he still is "acting" or if the appointment has been made, hoping that something will move one of these days. I anticipate that it will.

I assure you, Senator, that we will carefully consider your recommendations. I also want to congratulate you on the working relationship that exists between the medical school in Hawaii and the Tripler Medical Center. I think it is an excellent example of the private sector and military cooperation that is needed to bring both adequate and quality health care to our service people that they deserve.

Senator INOUYE. I am certain the medical school will be very pleased to hear that. I will convey the thought to them.

TRIPLER MEDICAL CENTER

Senator JEPSEN. Do you have any comments you would like to make at this time about Tripler Medical Center?

Senator INOUYE. I think Tripler, with the ongoing renovation, once it is completed, will be a first-class facility to care for the needs of the joint services in Hawaii. I think with those facilities and with the personnel there we should be able to meet just about any contingency.

We in Hawaii are extremely pleased and proud of the Tripler facility. As you may know, Mr. Chairman, we have no veterans hospital as one would find in most of the States, but Tripler has, by arrangement with the Veterans' Administration, set aside an adequate number of beds there so our veterans are receiving the care that men in uniform and active duty receive at the present time. I think they are coming out possibly with a better deal than some of the veterans in other veterans' hospitals.

Senator JEPSEN. Thank you for your testimony and your comments, and for both your continuing interest and good works in this area. We look forward to your support on the Senate floor to bring some of these things to pass.

Thank you, Senator.

Senator INOUYE. Thank you, Mr. Chairman.

Senator JEPSEN. Now, Dr. Beary and the Surgeon Generals, you might all do what we used to call in the service, "advance to be recognized" or something like that. [Laughter.]

I would again assure and remind the members of the panel that we have your written statements. They will be entered into the record as if read. In the interest of time—I have been advised there probably will be other members of the subcommittee here that have a deep interest in this—so to be assured that we have maximum time for questions and exchanges of ideas I would appreciate it if you would summarize your statements as much as possible.

With that, you may proceed. Welcome to all of you again. Dr. Beary?

STATEMENT OF JOHN F. BEARY III, M.D., ACTING ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. BEARY. Thank you, Mr. Chairman.

It is a pleasure to appear before your committee again to discuss defense health systems management and quality assurance.

I am keenly aware of the active and helpful role your subcommittee has played in supporting a military health care system which satisfies medical readiness requirements and provides quality care to all beneficiaries.

Following a brief overview of the system, I shall discuss specific areas of interest such as hospital cost trends, resource accountability, regionalization, and quality assurance.

The military health care system consists of medical resources in the Army, Navy, and Air Force, supplemented by CHAMPUS. It is a global system with 161 hospitals and 310 clinics, staffed by 151,000 military and civilian health personnel. A budget of $6.7 billion is required in fiscal year 1983 to operate the system, with a breakdown as

follows: $4.5 billion going for the provision of direct health care, the direct health care system; $1.1 billion for CHAMPUS, and another $1.1 billion for research, construction, and ancillary areas.

It is a large system with a sizable budget and manpower requirements, and the need to effectively manage it is apparent, particularly in light of the fact that the costs of providing health care are rising far more rapidly than any other segment of our economy.

HOSPITAL COST TRENDS

The administration's economic recovery program has successfully harnessed inflation in the economy as a whole. The Consumer Price Index for all items is projected to rise this fiscal year at an annual rate of only 2.5 percent. However, the hospital room portion of the index is projected to rise nearly 18 percent.

This growth has a tremendous effect on CHAMPUS costs in that hospital costs account for 65 percent of the CHAMPUS budget. It also affects the direct care system in regard to labor, equipment, and supply costs.

In DOD, the inpatient cost per occupied bed day rose 18 percent from fiscal year 1980 to fiscal year 1981. The increase experienced by CHAMPUS was about the same, although inpatient cost increases only partially explain the growth CHAMPUS has seen this past year.

RESOURCE ACCOUNTABILITY

Only 2 years ago, tracking these kinds of trends in the direct care system with any degree of accuracy was next to impossible. We now have in place and operational a Uniform Cost and Accounting Reporting System—UCA—which goes a long way toward providing uniform data that is required before meaningful intra- or inter-service analyses can be performed. While we are still fine tuning the system, we anticipate that its value to management will be significant.

Other soon-to-be-operational systems such as the Defense Eligibility and Enrollment System—or DEERS—the uniform staffing methodology, and a revision of the hospital workload measure methodology will greatly enhance our resource analysis capabilities.

REGIONALIZATION

All of these data, however, will be of little value unless a system exists which clearly defines lines of accountability and provides a mechanism which facilitates changes to improve productivity and cost effectiveness. The current system does not meet these criteria; however, with some modifications it can.

We have several initiatives underway and are looking at a number of others to make the system more responsive and accountable.

Principal among these is enhancement of the regionalization system. The current system has been somewhat helpful as a communications device but we are all aware of various criticisms that have been leveled against it. Through the Defense Health Council I have taken steps to strengthen the regionalization concept with the aim of clarifying accountability. The Council itself will have a new and more comprehensive role in oversight of these initiatives.

Specifically, my aim is to eliminate needless duplication of facilities, equipment, and services; promote more interservice sharing, particularly where two or more medical catchments overlap; and to improve communication and coordination channels by issuing regional reporting requirements.

In addition, there is a need to increase awareness of the nature of the military health care system. It needs to be viewed as one system, not three separate systems supplemented by CHAMPUS.

To underscore this, I recently sent a memorandum to the Assistant Secretary for Manpower of each service in which I discussed the tremendous growth in CHAMPUS utilization and costs and the fact that 55 percent of CHAMPUS dollars are spent on beneficiaries who live within catchment areas of military hospitals.

We estimate that CAMPUS will experience a $100 million shortfall in fiscal year 1982, and I have asked the Service Assistant Secretaries for their assistance in increasing the productivity and cost effectiveness of the direct care system in order to help keep CHAMPUS costs down—once again, viewing it as one system and not three or four separate systems.

QUALITY ASSURANCE

Finally, I would like to address the issue of quality assurance. A great deal of attention has been focused on the assessment and assurance of the quality of care found in the military health care system. Recent newspaper and television reports about this subject have concerned me. Therefore, I conducted a review of our policies and procedures in this area in accord with our strategic planning effort.

First, I must say that in general the quality of care provided in the military health care system is equal to and at times surpasses that provided in the civilian community. To say otherwise would be a great disservice to the thousands of men and women who make up that system and the 9 million beneficiaries it serves. That is not to say that some improvements are not needed.

Before many of these stories gained national attention, I recognized the need for policy clarification and emphasis in this area and established a new staff position of Director of Health Programs Evaluation and Quality Assurance. We have just selected an individual with an extensive and varied background in this area who is joining our staff, Diane Bolay.

As part of our review we looked at the credentialing policies of the three services. They are in accord with the Joint Commission standards and similar to practices followed in the civilian community. My conclusion is that if the service credentialing committee regulations are followed, one can detect and discipline incompetent health care providers.

In the course of the review one needed improvement became apparent. The medical services do not at present share information with the National Clearinghouse in Texas—the Federation of State Medical Boards—in contrast to the practice of the 50 States.

Therefore, I have instituted a policy to inform appropriate professional regulating bodies—such as FSMB—as to the identity of medical officers whose employment is terminated under circumstances in which their credentials were suspended, limited, or withdrawn at the time of their separation. In any case of limitation of credentials, a

review by the responsible command authority will be conducted to determine whether the medical officer involved should be considered for separation from the service.

Further, when a medical officer is ordered to practice in or receive medical training in a military or civilian facility other than that at which his file is maintained, the gaining facility will be fully informed of the appropriate information.

The Secretaries of the Military Departments are responsible to insure that these policies are carried out. I feel certain that if the new and existing policies are followed, the traditional high standards of military medical care will be maintained.

In conclusion, I pledge to work to assure that the Defense Health System will always provide the quality of medical care which I would desire for my own family.

Thank you, Mr. Chairman, I am happy to answer any questions you may have.

Senator JEPSEN. I plan to go ahead with the other witnesses so that we do not get into a duplication of questions, which often-times happens when people come and go. We want to get as many of them here as possible before I start asking questions, and maybe save time.

At the risk of violating any form of recognition of proper protocol here, I will just go from left to right, if I may. General Myers, the Surgeon General of the Air Force, you may proceed.

STATEMENT OF LT. GEN. PAUL W. MYERS, SURGEON GENERAL, U.S. AIR FORCE

General MYERS. Thank you, Mr. Chairman. I am pleased to have the opportunity to meet with you again and address quality assurance, risk management, resource accountability, inpatient hospital costs, and regionalization.

To address quality of care specifically for the Air Force, all of our Air Force medical facilities are required by regulation to adhere to the standards set by the Joint Commission on Accreditation of Hospitals. All Air Force hospitals seeking accreditation have been accredited.

The Joint Commission does not require a separate risk management program. However, the Air Force has implemented one. It was implemented in February 1980. Each facility is required to develop a system that uses information from committees, medical staff activity minutes, reports, surveys, audits, questionnaires, complaints, and personal observations to identify real and potential threats to optimal patient care.

The USAF Risk Management Council meets twice a year to discuss medicolegal trends and to develop methods for program improvement. Semiannual management cross-feed reports are provided to major command surgeons and staff judge advocates and to base medical facility commanders and legal offices.

CREDENTIALING

A careful screening and quality selection process is conducted by the U.S. Air Force Recruiting Service and the Air Force Manpower and Personnel Center Surgeon's Office. But we continue to experience some difficulty in getting accurate information concerning problem provid-

ers coming from the civilian community. This often is due to a fear of litigation.

Peer and credential review is an ongoing process once the provider enters the Air Force Medical Service.

Within the limitations of the Privacy Act, the Air Force does provide information to civilian hospitals on the professional competence of practitioners.

A more open exchange of information concerning individuals who have been decredentialed is needed between the civilian and Federal health care communities. I fully support legislation which would require such an exchange, but it would have to be as binding on the civilian community as it would be for the Federal sector. This will be a complex undertaking. The rights of the health care providers, the patient's health, and privileged patient information need to be protected. We must certainly deal with facts and not allegations.

PHYSICIAN SELECTION

I recently established an ad hoc committee to study accession of physicians both through the health professions scholarship program and the recruiting service.

The health professions scholarship program has proven to be an excellent source of physicians. This year, we selected 227 applicants for 4-year scholarships. Their average medical college admission test score was 64. We selected 531 alternates whose test scores were on the average 56. The average medical college admission test score nationally is only 47. So, we are selecting the best.

The quality of personnel on board is excellent. At the moment, more than 1,500 of our 3,600 Air Force physicians are board certified, and our military program graduates do extraordinarily well in specialty board examinations. Just a couple of examples: Of the 94 graduates in our radiology training program, 92 have passed their boards. Of 41 graduates of the family practice program, 41 have passed; and that high pass score also applies to other specialties.

In addition, our major training centers for enlisted personnel are institutionally accredited by the Southern Association of Colleges and Schools.

The same kind of quality is seen in our dental service, with our Air Force dental specialty training programs and general practice residencies accredited by the American Dental Association Council on Dental Education. Sixty of 66 CONUS dental services and 19 of 21 clinic dental services are accredited.

The system of checks and balances which is such an essential part of the Department of Defense Planning, Programing and Budgeting System, and the Air Force Research Management System, insure that the Air Force Medical Service provides optimum patient care to the maximum number of beneficiaries at reasonable cost.

Audits and reviews done by the General Accounting Office, the Defense Audit Service, the Air Force Audit Agency, the Air Force Inspector General, the Air Force Surgeon General himself, and the Air Force major commands confirm that resources are used prudently.

Regionalization is designed to increase productivity and achieve economy without unnecessary duplication of resources. The Tri-Service Regional Review Committees have been established and are working. I have encouraged cross-feed of information concerning regional accomplishments.

The Air Force began actively implementing a more formal exchange in the fall of 1981 but I would admit, there is still much work to be done.

I am proud of the Air Force Medical Service's resource management record. Our people traditionally have done more with less, and they have been truly innovative.

This is just a brief capsule or summarization of our complete report that has been submitted. Sir, I would be more than happy to answer any questions you may have with regard to the details of our programs.

[The prepared statement of Lt. Gen. Paul W. Myers follows:]

PREPARED STATEMENT OF LT. GEN. PAUL W. MYERS, SURGEON GENERAL, U.S. AIR FORCE

Mr. Chairman and members of the committee: I am pleased to have the opportunity to meet with you again and address the Air Force health care system and quality assurance.

Resources for us mean manpower, money and methods of improvement. Of these, people are the most valuable resource. I am proud of our more than 40,000 highly motivated health care professionals. They deserve adequate facilities, equipment, pay, training and our support. It is my goal to provide that support.

During my previous testimony before this committee, I addressed my first priority—medical readiness. Today, I will discuss several other critical issues—quality assurance and risk management, resource accountability, inpatient hospital costs and regionalization.

QUALITY OF CARE

We have worked hard over the years to develop and maintain a viable medical organization which provides quality care. Our management, operations, and quality have met the judgment criteria of our civilian colleagues' accrediting and reviewing organizations.

All Air Force medical facilities are required by regulation to adhere to the standards set by the Joint Commission on Accreditation of Hospitals (JCAH). This is the same organization which accredits civilian medical institutions. All Air Force hospitals seeking accreditation have been accredited. Only five received a 1-year conditional accreditation. The conditional accreditations were based primarily on building and life safety code problems. The latter factor will be a continuing problem in obtaining full accreditation until additional funding is provided to cover needed constructon costs. All hospitals undergo a continual review process to ensure that deficiencies are recognized and corrective actions taken.

The Quality Assurance Program is a JCAH standard required for accreditation. This standard became effective January 1, 1981. It provides for a comprehensive, integrated, ongoing objective assessment of important aspects of care and the correction of identified problems. The JCAH does not require a separate Risk Management Program for accreditation as a part of its Quality Assurance Program; however, the Air Force has implemented one.

Within the Air Force, risk management is a collective effort to avoid risk-creating incidents. Air Force emphasis in this area began as a result of the changing trend in public reactions to health care. Nationally, a significant increase in malpractice claims began in the mid-70s. The Air Force was not left untouched by this rise in claims. As a result, in June 1979, I directed the establishment of a Risk Management Program. Between September 1979 and January 1980, an intensive program was undertaken by the USAF School of Health Care Sciences to train risk managers, both in the United States and overseas to administer our program, which was implemented in February 1980. Each facility is required to develop a system that uses information from committees, medical staff activity minutes, reports, surveys, audits, questionnaires, complaints, and personal observations to identify real and potential threats to optimal patient care.

Our Risk Management Program complements the JCAH Quality Assurance Program. We have worked hard to get this program going. All of our facilities have not implemented a fully integrated program yet, but this is a high priority action and rapid progress is being made. We have established a USAF Risk Management Council which meets twice a year to discuss medicolegal trends and to develop methods for program improvement. This Council also recommends action on credentialing of health care providers and professional policies and procedures. Semiannual risk management cross-feed reports are provided to major command surgeons and staff judge advocates and to base medical facility commanders and legal offices. The data is used as teaching information. Lessons learned are addressed by the medical staff.

An effective quality assurance and risk management program requires the understanding and implementation of four activities by the entire medical staff—comprehensive data screening, education of staff and beneficiaries, integration of expertise and a problem-oriented approach.

I have requested that the Risk Management/Quality Assurance Programs be designated as "special interest" items by the Air Force Inspector General during inspections. Much work remains to be done, but I believe that our efforts are beginning to be effective.

CREDENTIALING

It is the responsibility of each medical recruiter, health care provider and medical facility commander, respectively, to carefully review each applicant, to report substandard performance, and to monitor staff member's credentials and capabilities.

A careful screening and quality selection process for all medical personnel is conducted by the USAF Recruiting Service and the Air Force Manpower and Personnel Center Surgeon's Office. On the whole, this process has been successful. We continue to experience some difficulty in getting accurate information concerning problem providers from the civilian community. This often is due to a fear of litigation.

Peer and credential review is an ongoing process once the provider enters the Air Force Medical Service. Air Force Regulation 160–41, Air Force Credentials Review of Health Providers, gives extensive guidance on credentialing. Recently, we have drafted an even more comprehensive credentialing regulation which is in process of being published.

The current Air Force credentialing program fulfills all JCAH requirements. The credentialing process is geared to ensure that health care providers are practicing within the scope of their abilities.

Within the limitations of the Privacy Act, the Air Force does provide information to civilian hospitals on the professional competence of practitioners. We do this in the same way as hospitals in the civilian sector. The gaining civilian hospitals where former members have applied for privileges direct inquiries to the Air Force hospitals where he or she previously practiced. This request must include a statement from the practitioner authorizing the release of this personal information. In response, our hospitals will forward information on his areas of practice and professional competence from the credentials file. Very few hospitals request this information and provide the authorization for release of data.

A more open exchange of information concerning individuals who have been decredentialed is needed between the civilian and federal health care communities. I fully support legislation which would require such exchange but it would have to be as binding on the civilian community as it would be for the federal sector. This will be a complex undertaking. The rights of the health care providers, the patient's health, and privileged patient information need to be protected. We must deal with facts, not allegations.

PHYSICIAN SELECTION

I recently established an Ad Hoc Committee to study accession of physicians through the Health Professions Scholarship Program (HPSP) and Recruiting Service. This committee looked at methods to identify which HPSP applicants would be more likely to elect the Air Force as a career and how to preclude commissioning potential problem physicians.

The HPSP program has proven to be an excellent source of physicians. We have been very successful in getting highly qualified applicants for this program. This year we selected 227 applicants to receive our four-year scholarships. The typical grade point average (GPA) for this group was 3.72 and their average Medical College Admissions Test Score was 64. In addition, 631 alternates were selected

with an average GPA of 3.56 and an average Medical College Admissions Test Score of 56. In comparison, the average Medical College Admissions Test Score nationally was 47.

QUALITY OF PERSONNEL

The overall quality of our people is excellent. Members of the officer corps are required to have college degrees in their specialties, with the exception of the Air Force Nurse Corps. The latter are required to be registered nurses; however, in 1980, 65 percent of the Nurse Corps had bachelors degrees or higher compared with 25.5 percent nationally. In 1981, 70 percent of Air Force nurses had bachelors degrees or higher.

All members of the Medical Service are required to obtain continuing medical education to keep up with the state-of-the-art in their respective fields.

More than 1,500 Air Force physicians are board certified. All Air Force physician residency training programs are accredited by the Accreditation Council for Graduate Medical Education. The quality of our programs is substantiated by the success rates of the graduates in board examinations and by the individual program ratings. For example the Urology Residency Program at Wilford Hall USAF Medical Center is rated number 1 out of 147 programs nationally.

Military program graduates do very well in specialty board examinations. The American Board of Obstetrics/Gynecology reported that the 1981 written board pass rate was 92 percent for the military, 88 percent for university programs, and 65 percent for community programs. Examples of Air Force success rates are: dermatology residency (Wilford Hall) 28 graduates—28 passed; radiology (Wilford Hall) 94 graduates—92 passed; obstetrics/gynecology (Wilford Hall) 38 graduates—38 passed; family practice (Carswell AFB) 25 graduates—25 passed; family practice (Scott AFB) 41 graduates—41 passed. On first attempt 98 percent of Wilford Hall psychiatric graduates passed compared to the national average of 52 percent. From 1978 through 1980, Wilford Hall-trained general surgeons taking the board exam for the first time had a zero percent fail rate. The Wilford Hall orthopedic residency ranks in the upper 15 percent of approved orthopedic residencies in the United States.

National in-service examination places the graduates of the psychiatric residency at USAF Medical Center Wright-Patterson above the norm in all programs and at the norm for university programs.

The medical technology internship programs at Wilford Hall and Malcolm Grow USAF Medical Centers are fully accredited by the National Accrediting Agency for Clinical Laboratory Sciences. During the last five years 90 percent of the selectees for the program had masters degrees. This is now a requirement. Each graduate of the internship must take the certifying examination given by the American Society of Clinical Pathologists.

Both major training centers for our enlisted technicians (the USAF School of Aerospace Medicine and the School of Health Care Sciences) are institutionally accredited by the Southern Association of Colleges and Schools. They are part of the campus of the Community College of the Air Force. Our training centers adhere to stringent standards of excellence. In addition, 36 courses are individually accredited by specialized accrediting bodies such as the Association of Surgical Technologists, National Society of Cardiopulmonary Technicians, American Dental Laboratory Technologists Association, American Optometric Association, and the National Registry of Emergency Medical Technicians. Two of our technician training programs are affiliated with a civilian university and operate as an extension of its campus.

The certification pass rate for Air Force physician assistants is 80 percent compared to 76 percent in the civilian community.

USAF DENTAL SERVICE

The competition for entry into the Air Force Dental Corps is steadily growing. We receive far more applications for entry as general dentists than we can accept. We are very selective. The Air Force dental specialty training programs and the general practice residencies are accredited by the American Dental Association Council on Dental Education. Sixty (60) of our 66 continental United States (CONUS) hospital dental services and 19 of the 21 clinic dental services are accredited by the American Dental Association Council on Hospital and Institutional Dental Services. The standards for accreditation are high. Those services which currently are not accredited are being reviewed and accreditation will be sought.

The Air Force has 381 specialists. Of those specialists, 104 are board certified. The remainder of the specialists, 277, are board qualified; however, many of them have not had the required time in specialty to take their specialty boards. They are encouraged to take their boards as soon as they are eligible.

MANPOWER

Staffing in all Corps continues to improve. The chart listed on the following page gives the current strength figures:

MEDICAL SERVICE STAFFING, FISCAL YEAR 1982[1]

	Authorized	Assigned	Percent
Medical Corps	3,692	3,502	94.9
Dental Corps	1,590	1,534	96.5
Nurse Corps	4,449	4,395	98.8
Biomedical Sciences Corps	2,237	2,133	95.4
Medical Service Corps	1,116	1,103	98.8
Total	13,084	12,667	96.8

[1] As of Apr. 30, 1982.

Physician specialty staffing remains a problem although there was significant improvement during the past year. Sixty-seven (67) percent of the critical specialty recruiting goal was attained in fiscal year 1981 compared to 26 percent in fiscal year 1980. Those specialties which have been designated as critical for fiscal year 1982 are: surgery (general, colon/rectal, neurological, orthopedic, urologic), obstetrics/gynecology, ophthalmology, otorhinolaryngology, hematology/oncology, rheumatology and neonatology. The long range outlook is for improved staffing in most critical specialties; however, general surgery, orthopedic surgery, ophthalmology and otorhinolaryngology will remain critical for several years.

Although we have been very successful in recent years in gaining adequate numbers of personnel, head room is needed. In order to meet our wartime requirements, an authorization for 5,155 physicians is essential. The additional physicians could be used effectively during peacetime.

RETENTION

In past years, the Air Force Medical Service has experienced a substantial turnover rate of officers, especially physicians. Some observers attributed the exodus of these officers totally to factors such as pay, assignments, promotions, and additional duties. The assessment was an oversimplification of the situation. Admittedly, these considerations play a significant role in retention, but do not represent a complete picture.

Management practices, personalized career planning, state of the art equipment, and adequate facilities and staffing also play an important role in retention.

In 1978, Project KEEP (Keep Each Eligible Person) was initiated in an effort to improve retention. This program recognizes that the Medical Service cannot afford the luxury of simply hoping good medical personnel will elect to stay for an Air Force career. Project KEEP places emphasis on the needs and concerns of the individual. It has paid off. We estimate that this year in excess of 70 percent of those physicians who are eligible to separate will choose to continue their career in the Air Force. The increased pay for physicians has contributed to this retention.

SUPPORT PERSONNEL

Air Force physicians and physician extenders have identified the lack of adequate support personnel as an irritant which directly impacts on the care that can be provided. The current overall ratio in the Air Force ambulatory care setting is 1.64 support staff per provider. The current ratio in similar civilian settings exceeds three support staff per provider.

During reviews of our manpower standards, each work center support ratio is being critically examined for sufficiency. These reviews are identifying needs for increased support personnel authorizations. We are currently planning an increase of 4,880 support personnel by fiscal 1988.

If your health care providers *are to function* in the most efficient manner, they must have adequate support personnel. Congress recognized this need and provided 333 additional spaces in the fiscal year 1980 Authorization Act. This small number has minimally improved support in the clinics. My personal belief is that one more medical technician or nurse per clinic physician is an absolute necessity.

EQUIPMENT

Health care providers also must have the same state-of-the-art equipment found in comparable civilian hospitals. All physicians and other providers must be equipped with systems and instruments capable of providing diagnostic and treatment services commensurate with the level of care they are expected to provide. Our larger regional hospitals and medical centers require a greater sophistication of equipment to support the referral workload and specialty care they provide.

The recommended average life of medical equipment is eight years. The Air Force Medical Service has established an outstanding system to review its equipment requirements. Before new equipment is purchased, every attempt is made to use available resources. If the equipment is not available and costs more than $3.000 (investment equipment), the purchase must be approved by the Major Command Surgeon and the Surgeon General's Office. Each is reviewed by the appropriate clinical consultant to the Surgeon General. The most economical piece of equipment for the stated need is purchased through the competitive bid process.

If the request is for equipment priced at over $200,000, there are additional reviews and a much more detailed justification process. This includes a cost analysis to show it is less expensive to buy the equipment than send patients to civilian hospitals and a Tri-Service review to see if it is possible to absorb the workload at another military facility in the area. Final approval rests with the Department of Defense Health Council. If the Council approves, the equipment is purchased when funds become available.

To help users identify replacement requirements, we have developed a computer program that annually lists all replacement candidates for the next three years. Factors considered are life expectancy, age, maintenance history and condition. The computer takes this information, compares it against predetermined conditions, and identifies when a replacement may be needed. An on-site review is conducted by management to validate the computer analysis. Every effort is made to assure that equipment is not unnecessarily replaced and that only essential new equipment is purchased. The Air Force Medical Service is proud of its record in this regard.

For the past three years, over 7,000 requests have been approved for equipment ranging from computerized scanners to dictation systems. Forty-five (45) percent of those requests were for items other than replacements. This is indicative of a strong effort to support our providers with up-to-date equipment. Funding from replacement, modernization and initial outfitting of medical/dental investment equipment ($3.000 or over) for fiscal year 1982 is $23.8 million compared to $18.9 million in fiscal year 1979. Yet funding has not kept pace with our needs. The fiscal year 1983 budget is 38.3 million. Of that amount $17.7 million is for war reserve materiel (WRM) with the balance of $20.6 million for replacement, modernization and initial outfitting equipment. Our estimated end of fiscal year 1982 inventory is approximately $196 million. The fiscal year 1982 budget will support a replacement cycle of only about 11 years. An additional $3.9 million would be required to reach the eight-year replacement objective necessary to ensure that state-of-the-art equipment is available.

In fiscal year 1979, we had approved unfunded requirements of $4.7 million. By the end of fiscal year 1984, we project approved unfunded investment equipment requirements to be over $22 million. This carry-over has been caused by the high costs associated with rapid advances in technology, new safety standards statutes (e.g., X-ray equipment) and our responsibility to provide the highest quality of medical care to our beneficiary population.

Continued support for acquisition of new state-of-the-art equipment must continue. It is a vital factor in the retention of quality personnel. The increased equipment acquisition has had a positive effect on the morale of our staff. Patient benefit is obvious.

FACILITIES

The upgrading of our medical facilities continues to be of great concern. More than half of our health care facilities are over 20 years of age and are in need of replacement or modernization.

Following two rather bleak years in our modernization program which totalled a half million dollars, a turnaround came as the fiscal year 1981 program was funded at $29 million and included six projects. The medical construction program for fiscal year 1982 is $126 million and includes life safety upgrades at two facilities and the modernization and addition to one of our medical centers and one of our base level hospitals.

In an effort to hasten the program to upgrade and modernize our health care facilities worldwide, we have initiated a program called CHAMP (Clinic and Hospital Accelerated Modernization Program). This is a planned effort to eliminate serious facility constraints to health care delivery. At a minimum, the current five-year Air Force program must be fully funded. This plan includes $1.3 billion of identified medical construction requirements. The remaining known requirements of $357 million will be requested in fiscal year 1989 during the Program Objective Memorandum cycle. Therefore, our total requirement is $1.7 billion. Our success depends on the support of Congress in providing the funding.

To adequately care for our beneficiary population, our medical facilities must be designed and built to serve their needs. The size of these facilities has been limited by law. New proposed legislation, currently being coordinated within the Executive Branch, would permit DOD to program more space for retirees and their dependents when building new facilities or renovating existing ones. This would allow sizing of certain DOD hospitals at levels more supportive of projected readiness needs while reducing expensive CHAMPUS costs.

CHECKS AND BALANCES

The Air Force Medical Service budget, unlike the other services, is an integral part of the line management structure. We share a common resource allocation and accountability system. Our expenditures must be justified at base, command, and headquarters level and must compete with other elements for funding at each level.

In addition, the system of checks and balances which is part of the DOD Planning, Programming and Budgeting System and the Air Force Resource Management System, ensures that the Air Force Medical Service provides optimum patient care to the maximum number of beneficiaries at reasonable cost.

Audits and reviews by the General Accounting Office, Defense Audit Service, Air Force Audit Agency, the Air Force Inspector General, Air Force Surgeon General and Air Force Major Commands confirm that resources are used prudently.

INPATIENT HOSPITAL COSTS

Through the Uniform Chart of Accounts (UCA), implemented in fiscal year 1980, we have a uniform cost accounting and workload reporting system. This system of resource accountability provides management information on total costs including overhead and base support for inpatient, ambulatory, ancillary and dental care. The UCA system ensures comparability within DOD for data collection.

In-patient hospital costs are rising in Air Force medical treatment facilities. In fiscal year 1978, the average cost per occupied bed day was $152; in fiscal year 1981, it was $216. The average cost per patient stay was $882 in fiscal year 1978 and $1,231 in fiscal year 1981.

REGIONALIZATION

The regionalization concept is designed to increase productivity and achieve economy without unnecessary duplication of resources. This type of program facilities sharing while permitting each of the services to support its medical mission. Tri-service Regional Review Committees have been established. They perform functions such as assessing health service capabilities and operations and the need for increased or decreased services, facilities, or other resources within the region, and identifying management improvements. Narrative progress reports are submitted by the committees to each Surgeon General. I have encouraged crossfeed of information concerning regional activities and accomplishments. The Air Force started actively implementing a more formal exchange in September 1981. Such interaction between regional medical treatment facilities

benefits both the personnel locally and contributes to a more efficient Medical Service. There is still much work to be done.

FUTURE HEALTH CARE

I am proud of the Air Force Medical Service's resource management record. Our people traditionally have done more with less. They have been innovators.

Today, I ask that you acknowledge their efforts by authorizing the resources they require to provide the best possible care to every Air Force beneficiary.

I would be happy to answer any questions you have concerning the Air Force Medical Service.

Senator JEPSEN. Thank you.

Do you have any statement, Senator Exon?

Senator EXON. I have no statement, Mr. Chairman.

Senator JEPSEN. Admiral Cox, you may proceed.

STATEMENT OF VICE ADM. J. WILLIAM COX, SURGEON GENERAL OF THE U.S. NAVY

Admiral Cox. Thank you, Mr. Chairman, members of the committee. I am pleased to appear before you once more this spring to discuss the agenda that is before us.

I have submitted a more detailed statement and will summarize that at this time.

My primary mission, of course, is to be prepared to medically support the Navy and Marine Corps in time of war. During peacetime, in addition to preparing to carry out that primary mission, we engage in the secondary mission of providing cost-effective health care to eligible beneficiaries.

In order to carry out this medical-dental mission, a wide-ranging mix of personnel, equipment, and facilities is required. These include Marine Corps organic medical support with its field-trained personnel, equipment, and highly mobile patient resuscitative and holding hospital capability; shipboard facilities ranging from 1 corpsman sickbays aboard small ships to the 70-bed facility on the *Nimitz* class carrier; mix of rapidly deployable hospital ships and fleet hospitals for contingency response; numerous overseas clinics and hospitals to support fleet units and Fleet Marine Corps; and a large CONUS-based definitive and restorative care medical system to provide peacetime patient care, expansion capability for wartime, and a trained supply of medical personnel ready for immediate deployment.

In order to maintain this system, we must have a training system to provide the manpower; a research capability to insure that the best techniques and methods are available; a viable reserve program with adequate numbers of trained personnel to provide for augmentation requirements, and a management organization to insure that the system is ready to meet its contingency mission; and to provide cost-effective, quality medical care in peacetime.

As Surgeon General of the Navy, I am responsible to the Chief of Naval Operations for management of the Navy medical system. In order to assist me in fulfilling this responsibility, medical department flag officers serve on the staffs of the Commander in Chief, Atlantic Fleet; Commander in Chief, Pacific Fleet; Commandant of the Marine Corps, and as major deputies in the Bureau of Medicine and Surgery. Other medical personnel also function in many other naval organizational elements.

In addition, I serve as the Chief of the Bureau of Medicine and Surgery. In the Bureau we manage the day-to-day operations of the Medical Department and plan for functional improvements and wartime readiness. The Medical Department is organized into major medical and dental regions across the country and overseas, commanded by senior personnel reporting directly to me. I rely on these officers for management of all patient care and preventive medicine in their regions. Many of these regions include smaller hospitals and branch clinics which report to the regional commander.

This regionalized system insures that my policies and standards are enforced down to the smallest medical unit, and apportions medical resources with equity to provide the best possible quality care to our entire Navy family.

The Navy Medical System complements and interacts with the Tri-Service Regionalization System. At the headquarters level, my senior staff and I interact with senior staff in DOD Health Affairs and the other services. At the field activity level, commanding officers in the Navy Medical Department are members of the Tri-Service Coordinating Committees of each DOD Region.

This field-level interaction promotes coordination of patient care in each area of the country, enhances efficiencies by eliminating unnecessary duplications, and provides a forum for regional cooperation in resource sharing.

The hearing today is specifically aimed at management of health care systems and quality assurance. Having discussed the overall management structure of the medical department at the top echelon of command, I will now address the specifics of management, particularly resource management in our peacetime regionalized medical system.

To insure optimum allocation of appropriated funds, a detailed review of each activity takes place concurrent with annual budget development. Program managers in headquarters review budget requests for accuracy and make recommendations based on anticipated availability of resources. The resources advisory group, composed of senior headquarters staff, reviews recommendations for executability, completeness, and conformance with established goals and established Navy policy, regulation, and law. Final adjustments are then made and the funds apportioned to the activities.

Subsequently, program managers located in headquarters compare monthly accounting reports with regional financial plans to track progress. They hold a midyear review in March, similar to the initial budget review, and make necessary adjustments within resource constraints.

To further insure that programs are executed as directed and prevent waste and abuse, numerous other controls and reviews are conducted on a continuing basis.

Within headquarters I have established an Internal Review Division to conduct special audits and investigations of the management of all medical department resources. This division monitors various audit reviews, including those conducted by the General Accounting Office and the Defense and Naval Audit Services, in order to insure that the recommendations of these agencies are evaluated and implemented as appropriate.

Two Inspectors General, one medical and one dental, are tasked to carry out the naval command inspection program for all activities under my command.

I have also formed an executive level Council for Oversight and Review to direct our efforts to prevent fraud, waste, and abuse. This Council reviews the findings and recommendations of various audit, inspection, investigative, and accreditation bodies, and makes recommendations for change in the existing systems of control.

I am particularly proud of another recently implemented initiative, our quality assurance and risk management program, specifically designed to identify, study, and correct problems found in the health care delivery process. We now provide both conceptual and procedural guidance to our medical treatment facilities through a comprehensive quality assurance and risk management manual.

Within this program, a Quality Assurance/Risk Management Committee is established at each naval medical treatment facility, which insures a direct pipeline to the commanding officer for coordinating quality assessment activities.

Each facility is also required to evaluate the appropriateness and quality of care through a series of ongoing reviews.

Our quality assurance program also includes a credentials review process to assure satisfactory qualifications of health care providers. An annual re-evaluation insures clinical competence is maintained at a level consistent with privileges granted.

Since high-quality, cost-effective care is a matter of primary concern to me, I have put particular emphasis on developing a sense of commitment to this program from my top managers. In my opinion, and in the opinion that has been expressed by those external to the Navy, our quality assurance/risk management program could serve as a model for the civilian community.

Thank you for the opportunity to talk with you about Navy medical management and the delivery of quality health care. I stand ready to answer your questions.

[The prepared statement of Vice Adm. J. William Cox follows:]

PREPARED STATEMENT OF VICE ADM. J. WILLIAM COX, MEDICAL CORPS, U.S. NAVY, SURGEON GENERAL, DEPARTMENT OF THE NAVY

Mr. Chairman and members of the subcommittee: I am Vice Admiral J. William Cox, Surgeon General of the Navy. I am very pleased to appear before you once again this month—this time to discuss management of the Navy Health Care System and Quality Assurance and Risk Management.

The Navy Medical Department has the primary mission to be prepared to provide medical support to the Navy and Marine Corps forces at sea, in the air, and in the field in time of war. In order to maintain and restore functional health, return trained personnel to duty, and minimize disability, the Medical Department must be mobile, and flexible, and it must have the capability of rapid response. In peacetime, it safeguards and promotes the health of the Naval and Marine personnel to assure combat readiness, trains our medical personnel for their combat mission, and concurrently provides a cost-effective health care benefit to the families of active duty and retired personnel. In the event of a national emergency or mobilization, the Medical Department team must be ready with a fully prepared base of highly trained, experienced personnel, both active and reserve, to provide medical support anywhere on the globe.

As Surgeon General of the Navy, I am responsible to the Chief of Naval Operations for the total Medical System within Navy. In order to carry out this responsibility, Medical Department flag officers serve on the staffs of Commander in Chief, U.S. Atlantic Fleet; Commander in Chief, U.S. Pacific Fleet; and the Commandant of the Marine Corps; and as major deputies in the Bureau of

Medicine and Surgery. Medical personnel also function in many other Navy organizational elements such as training, personnel, research, supply, and systems analysis. This ensures that Navy policies are reflected across the wide spectrum of Navy medical facilities, and provides the necessary feedback to monitor the program.

In addition, I serve as the Chief of the Bureau of Medicine and Surgery. As such I have under me a capable group of flag officers who function as Assistant Chiefs for Professional Development, for Planning and Resources, for Health Care Programs, and for Dentistry, who provide the broad management for the Medical Department. I also have special assistants in such areas as Inspector General, Medical Readiness, and Internal Review who provide the control checks to ensure compliance with directives and policy. In the Bureau we manage the day-to-day operations of the Medical Department, plan for functional improvements and wartime readiness, we provide review and oversight of our medical system.

In the fixed medical activity system, the Medical Department is organized into major medical and dental regions across the country and overseas, commanded by senior medical and dental personnel who report directly to me, and on whom I rely for management of all patient care, preventive medicine, and other mission responsibilities in this region. Under each of the regional commanding officers are smaller hospitals and regional clinics which support large Navy and Marine Corps bases, and a system of branch clinics which support smaller units.

This regional system ensures that my policies and standards are enforced down to the smallest medical unit, and that medical resources are apportioned in a manner which takes into account the best possible quality care and equity in providing health care services to our entire Navy family.

Since all three services provide medical support to beneficiaries of each other, and to ensure that the most effective care is provided throughout the world, the Navy system complements and interacts with the Tri-Service Regionalization System. At the headquarters level, I and my senior staff interface with the Assistant Secretary of Defense for Health Affairs, Army and Air Force in the Defense Health Council, the Medical Mobilization Steering Committee, and the Tri-Service Surgeons General Council. At the field activity level, each of my regional commanding officers and their subordinate commanding officers are members of the Tri-Service Coordinating Committee in each DOD region. Today, thousands of beneficiaries of each service receive patient care in other service facilities, a form of resource sharing which amounts to hundreds of millions of dollars. Close cooperation and coordination between military treatment facilities is an absolute necessity. This facility interaction promotes coordination of patient care in each area of the country, enhances efficiencies by exposing initiatives that would be unnecessarily duplicative, and provides a forum for regional cooperative initiatives in resource sharing. Since Public Health Service and Veterans Affairs representatives attend these meetings, this also provides a forum for exchange between all federal medical facilities and a ready review of sharing possibilities. A recent case in point is the closure of the Public Health Service facilities. In areas where Navy activities were colocated with PHS clinics and hospitals, the coordination of the transfer of patient care took place through the local coordinating committees.

In order to carry out the medical/dental mission, a wide ranging mix of personnel, equipment and facilities is required. These include Marine Corps organic medical support with its field trained personnel, equipment and highly mobile patient resuscitative and holding hospital capability; shipboard facilities ranging from the one corpsman sickbay aboard small ships to the 70 bed facility on the *Nimitz*, class carriers; a mix of rapidly deployable hospital ships and fleet hospitals for contingency response; numerous overseas clinics and hospitals to support the fleet units; and a large CONUS based definitive and restorative care medical system to provide the peacetime patient care, expansion capability for wartime, and a trained supply of medical personnel ready for immediate deployment.

In order to maintain this system, we must have a training system to provide the manpower, a research capability to ensure that the best techniques and methods are available, a viable reserve program with adequate numbers of trained personnel to provide for augmentation requirements, and a management organization to ensure that the system is ready to meet its contingency mission in wartime, and to provide cost effective, quality medical care in peacetime.

Todays hearing is specifically aimed at management of the health care system and quality assurance. I have already discussed the overall management structure

of the Medical Department at the top echelon of command. I will now address the specifics of management, particularly resource management, in our peacetime, regionalized medical system.

The extent to which the Navy Medical Department fulfills its mission depends on the availability and management of resources: personnel, funds, facilities, and equipment. These resources provide the capability to deliver essential inpatient, outpatient, and adjunctive health care services to all authorized beneficiaries.

The start of any fiscal year resource requirements development is based upon the Defense Guidance, which outlines broad goals and establishes priorities. All Navy claimants develop their requirements from this base and submit them to the Chief of Naval Operations, who then establishes priorities and develops the Navy program within the funds available to Navy. The result is the Navy Program Objective Document, which is submitted to the Secretary of Defense for approval. Final decisions are then incorporated into budget formats, once again reviewed by the Secretary of Defense and also the Office of Management and Budget, and published as the President's budget for submission to Congress. After Congressional decisions and the final appropriation bill, allocation of resources to field activities take place.

Concurrent with the budget development, a detailed review of each activity takes place utilizing data from the standardized Uniform Chart of Accounts and Uniform Staffing Methodologies reports. Each regional medical and dental center submits a detailed budget in July for the next fiscal year which justifies requests in terms of workload, price increases, new programs, and changes in missions. The budget reflects the requirements for all the activities in the medical region, shown separately for each major activity. They are reviewed by each program manager in the Bureau of Medicine and Surgery for content and accuracy, and recommendations are made based upon anticipated resource availability. After program managers submit their recommendations, the total program at each activity is looked at in the gross sense for executability, completeness, and conformance with the goals of the Surgeon General and established Navy policy, regulation and law. Final adjustments are made and the funds apportioned to the activities.

After receipt of their funding, each region develops a detailed financial plan which is sent to headquarters, and monthly accounting reports are compared with the plan to ensure all programs are on track.

Halfway through the year, a midyear review is held. Each region reviews its situation based upon actual experience, outlines problems that were unanticipated, and a total review is completed similar to the initial budget review. Appropriate adjustments are made within resource constraints, and a new financial plan is submitted.

Each regional commanding officer is personally responsible for execution of the financial plan as approved. Within his region, he has the authority to shift funds between his subordinate activities. Minor adjustments may be made and subsequently reported by submission of a revised financial plan. Major adjustments require prior headquarters approval.

Throughout this entire process, my comptroller keeps me personally informed and major decisions are made by me. In order to further ensure programs are executed as directed and to prevent waste and abuse, numerous other controls and reviews are conducted continually.

Within headquarters I have established an Internal Review Division, reporting directly to the Comptroller of the Bureau of Medicine and Surgery, which conducts special audits, studies, and investigations of the management of all Medical Department resources. This division is specifically responsible for monitoring of audits and reviews conducted by the General Accounting Office, Defense Audit Service, Naval Audit Service, and other audit and investigative organizations, and for ensuring that recommendation of these agencies are evaluated and implemented as appropriate. The Internal Review Division also examines internal management controls at all levels of the Medical Department and determines their adequacy in concept and their effectiveness in application.

The Inspector General, Medical, and Inspector General, Dental, are tasked to carry out the Naval Command Inspection Program for all medical and dental activities under the command of the Bureau of Medicine and Surgery. It is their mission to inquire into the professional, technical and administrative operation of each field activity, by means of routine command inspections and special inspections as required. The Inspectors General review the overall effectiveness of the command in performing its mission, including its use of resources, both manpower and dollars, its performance in the areas of mobilization readiness, training and personnel, support of the Navy and Marine Corps operational units it

serves, and other functions of particular interest to the Navy Inspector General and the Surgeon General. Discrepancies found and suggestions for improvement made during command inspections are carefully reviewed and corrective action is monitored.

I have also formed a Council for Oversight and Review to direct our efforts to prevent fraud, waste, and abuse. The council is chaired by my Deputy, and has as members: the Inspector General, Medical; the Inspector General, Dental; the Comptroller; the Director of Internal Review; the Legal Advisor; the Director of Risk Management; and the Executive Assistants of the Bureau. This council directs Medical Department relationships with audit, inspection, investigative, and accreditation bodies. The council reviews all findings and recommendations of these groups and make recommendations for change to existing systems of control.

Another initiative recently implemented and of which I am particularly proud is our Quality Assurance/Risk Management Program. While still undergoing early growing pains, it is specifically designed to identify, study, and correct problems found in the health care delivery process. We now provide both conceptual and procedural guidance to our medical treatment facilities through a comprehensive Quality Assurance/Risk Management Manual. The Manual was written to meet our unique requirements as well as the Joint Commission on Accreditation of Hospital standards.

The establishment of a Quality Assurance/Risk Management Committee at each Navy Medical Treatment Facility ensures a direct pipeline to the Commanding Officer in coordinating quality assessment activities. It also is designed to centralize the review process which requires a hospital-wide, integrated, coordinated, problem-focused approach to quality assurance activities. The committee integrates the findings of numerous and traditionally fragmented committees, and is required to resolve—not merely discover—problems in delivering quality health care.

Each facility is required to evaluate the appropriateness and quality of care through a series of ongoing reviews. The Bureau of Medicine and Surgery monitors the results of these reviews, as well as those of Joint Commission on Accreditation of Hospitals and the Medical Inspector General, subsequent command corrective action reports command incident report summaries, patient satisfaction summaries, and Consumer Council Agenda issues relative to patient concerns and dissatisfactions. This diverse material is examined with an eye toward detecting problems within the health care delivery system at the command level, so that corrections can be made.

Our Quality Assurance program also includes a credentials review process to assure satisfactory qualifications of health care providers. Qualifications of physicians, dentists, and paramedical practitioners are evaluated by a credentials review committee before clinical privileges are granted. An annual reevaluation assures clinical competence is maintained at a level consistent with privileges granted. Upon transfer, a practitioner's credentials file is mailed to the Commanding Officer of his or her next duty station. This provides for exchange of information about practitioners throughout the Navy health care system. Clinical care privileges are not transferable, but must be reapplied for upon reporting to each medical activity.

Using the guidelines of this program as a baseline, subordinate commands can establish goals, objectives, and priorities for assessing health care and health care delivery problems, and determine plans of action to achieve the desired results.

Since high quality, cost effective care is a matter of primary concern to me, I have put particular emphasis on developing a sense of commitment to this program from my top managers. In my opinion, our Quality Assurance/Risk Management program could serve as a model for the civilian community.

Thank you for the opportunity to talk with you about Navy medical management and the delivery of quality health care.

I stand ready to answer your questions.

Senator JEPSEN. Thank you, Admiral.

General Mittemeyer, you may proceed.

STATEMENT OF LT. GEN. BERNHARD T. MITTEMEYER, SURGEON GENERAL OF THE U.S. ARMY

General MITTEMEYER. Thank you, Mr. Chairman. It is again my pleasure to be with you today. I will also summarize my statement, and much of what has been said is applicable to the Army.

In regard to regionalization, there are many DOD-wide common features that provide us opportunities for coordination, even though many of the features are unique to the Army and our specific health care system.

However, I am firmly committed to the concept of regionalization of our health resources wherever possible. There is no doubt that we can improve the quality of health care and do so more efficiently by utilizing each other's available resources. I intend to continue to develop and exploit opportunities for further coordination and cooperation in the future.

The Army Medical Department already participates in many such cooperative programs with the other Federal agencies and certainly, we can provide better care for the members of the various Federal agencies and their family members.

In regard to sharing, the Army has long supported the development of legislation which would remove the legal obstacles to the sharing of services with the Veterans' Administration, and the recent passage of Public Law 97–174, that is the Federal Health Resources Sharing Act, has removed many of these obstacles and we certainly look forward to working with the other Federal agencies in developing guidelines to implement the provisions of this law.

Members of the medical treatment facilities in our regions established by the Department of Defense generally meet on a regular basis to discuss and effect arrangements which foster improved and cooperative medical care. The success of this system is reflected in numerous accomplishments which already have been achieved.

At a higher level, we are also involved in various arrangements with other Defense health care organizations which would promote utilization of resources and improve the quality of patient care.

Specifically, along with the Navy we provide optical fabrication for the Department of Defense and VA beneficiaries. We also have eliminated budget duplication in basic courses in health care. Another excellent example would be our common effort in the combat casualty care course in the training of our young physicians and other health care providers and the impact on readiness that this has had.

There are obviously many other opportunities available to further improve coordination and cooperation at the regional level to effect better resource utilization and improve the quality of care, and I intend to pursue these opportunities to the maximum extent possible with my colleagues.

With regard to quality assurance and risk management I believe that quality health care is a product of several essential elements. Obviously, the provider is the key element, but equally important are quality facilities and state-of-the-art equipment.

Our quality providers are assured by high entrance standards and a good program of initial and continuing training and education.

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With regard to equipment, it is important that we meet the highest safety standards to prevent the possibility of litigation and of course have an active quality procurement program in effect.

Quality health care depends, as I said earlier, on the provider. We have a variety of programs in effect that produce dedicated professionals, starting with an excellent selection program from very competitive medical schools into our own internship program, and then through our residency training programs and fellowship programs. These physicians are then assigned to our community hospitals where they provide primary service.

In addition to that, the vast majority have an opportunity to be assigned to a field medical unit either at the division level, brigade level, or battalion level.

Modern facilities and equipment are also essential ingredients of quality health care. Currently all our CONUS facilities are accredited by the Joint Commission on Accreditation for Hospitals. We have recently extended this critical review to our hospitals in Europe. We already have our medical centers both in Landstuhl and Frankfurt accredited and are currently renovating each of our hospitals in Europe and specifically are looking forward to similar accreditation by the JCAH at Nuremberg and Berlin this year.

Our equipment modernization program has also been successful in both procurement and installation of state-of-the-art equipment.

However, even quality people, modern facilities, and state-of-the-art equipment cannot assure quality care. Comprehensive and continuing mechanisms for monitoring such care must be in existence, and specifically for that we have a very effective credentialing process. That is where we actually review each physician who comes into our treatment facilities, whether he be a new addition or a reassignee. This credentialing action determines what medical responsibilities and privileges the health care provider will be granted.

In addition to the credentialing process, a very active utilization review process, auditing of the physician and the other health care providers' practices; tissue committees, and a Therapeutics Agent Board for drug utilization are all in effect, and other committees audit deaths, unimproved cases, complications, infections, transfusions, et cetera.

The establishment and function of these committees are subject, of course, to review at least every 3 years by the Joint Commission, as well as by our own Health Services Command Inspector General, as well as the Department of the Army Inspector General.

As an adjunct to these committees, then, we also have a very active risk management program ongoing. Specifically, we have a risk manager assigned to each facility, and it is his responsibility to insure that the local staff judge advocate reviews all unusual occurrences to prevent the possibility of claims against the Government. At the same time we also ask my own adviser in legal medicine to assist me on the review of all these cases.

As far as resource accountability is concerned, it is ultimately a function of the command. It is the Army's control mechanism to insure that resources are expended on those missions tasked to elements of the Army. Specifically for the Army Medical Department, various commands are held accountable for the resources. The Health Services Command is responsible for all facilities in the Continental United

States, Alaska and Hawaii, as well as Panama. The Seventh Medical Command is responsible in Europe, and the Eighth Medical Command in Korea.

The Surgeon General's Office is specifically responsible for its field operating agencies which work directly under the Surgeon General's supervision.

Resources are then allocated based on Army tasked missions, and are further distributed to the operating activities based on their individual missions.

In conclusion I would like to state—or restate—my commitment to the highest quality of care for the soldier, his or her family and, of course, our retirees. A most important goal during my tenure is to further improve both the quality and professionalism of our health care team and, through them, the health care we deliver.

I believe that an emphasis on regionalization as well as better utilization of our common resources to be one means of accomplishing this. Quality medical care is a part of the esprit that affects the morale of each of our soldiers, and it will insure their optimum performance in peace and in war, and certainly their maximum survivability on the battlefield.

Thank you, Mr. Chairman and Senator Exon, I thank you for the opportunity to appear before the committee.

[The prepared statement of Lt. Gen. Bernhard T. Mittemeyer follows:]

PREPARED STATEMENT BY LT. GEN. BERNHARD T. MITTEMEYER, THE SURGEON GENERAL, DEPARTMENT OF THE ARMY

Mr. Chairman and members of the committee, I am the Army Surgeon General and it is again my privilege to be here today. I will briefly discuss Army perspectives on regionalization, resource accountability, quality assurance and risk management.

REGIONALIZATION

Although there are many unique features of the Army and our health care system, there are also many DOD-wide common features that provide us opportunities for coordination and cooperation with other federal agencies.

I am firmly committed to the concept of health resources regionalization, where possible, as it applies to the Armed Forces and other federal agencies. I see this concept as an opportunity to improve the quality of health care and to more efficiently utilize available resources. While there has been much progress towards coordination and cooperation in the past, I intend to continue to develop and exploit opportunities for more coordination and cooperation in the future.

The Army Medical Department already participates in many areas of cooperation and coordination with other Federal agencies. Over one-fourth of the beds in our treatment facilities are occupied by Navy, Air Force or other Federal agency personnel and their dependents. We share many services with other Federal agencies which are of mutual benefit to those concerned. Some examples of such services at the treatment facility level are specialized medical services, graduate and continuing medical education, staffing, computer services and such ancillary services as laundry and equipment repair.

The Army has long supported the development of legislation which would remove the legal obstacles to the sharing of services with the Veterans' Administration. The recent passage of Public Law 97-174, Federal Health Resources Sharing Act, has removed many of these obstacles and we look forward to working with the other Federal agencies in developing the guidelines to implement the provisions of this law.

The Department of Defense has established formal regions throughout the world to promote these and other areas of cooperation between the Services. Members of the medical treatment facilities in these regions generally meet on a

regular basis to discuss and effect arrangements which foster improved medical care. The success of this system is reflected in the numerous accomplishments which have been achieved. At a higher level, we are involved in various arrangements with other Defense health care organizations which promote improved utilization of resources and quality of patient care. We participate in the Armed Services Medical Regulating System which directs patients to the nearest capable medical facility regardless of Service. Along with the Navy, we provide optical fabrication for DOD and VA beneficiaries to different regions throughout the world. We participate in the Interservice Training and Review Committee to coordinate training opportunities and eliminate duplication, wherever possible. One notable example of this is the Combat Care Casualty Course in which the three Services participate equally. Of course, there are many opportunities available to further improve coordination and cooperation at the regional level so as to effect better resource utilization and improve the quality of care. I intend to pursue these opportunities.

QUALITY ASSURANCE AND RISK MANAGEMENT

I believe quality health care to be a product of several essential elements. The provider is undoubtedly the most crucial of these elements. Quality providers are insured by high entrance standards and a good program of initial and continuing training and education. To support these health professionals, quality facilities and equipment are equally necessary. These are insured by a program of procurement, maintenance, and replacement to meet the highest health and safety standards. To bind the provider, the facilities and the equipment together in the delivery of quality care, a comprehensive system of professional standards and reviews must exist and be consistently and continuously applied.

Quality health care depends first on the provider. The Army Medical Department today has a variety of programs that produce well trained and dedicated professionals. Our physicians come from a variety of highly competitive school programs into equally competitive intern programs. After internship they serve in various field medical units or enter various Army residency training programs. The results of this lengthy process are highly qualified physician specialists that consistently do better than their civilian contemporaries in specialty board examinations. The same impressive level of training and dedication also applies to other members of our health care delivery team. Thus, our personnel rate among the most highly trained and dedicated anywhere.

Modern facilities and equipment are also essential ingredients of quality health care. Currently, all CONUS facilities have been accredited by the Joint Commission on Accreditation for Hospitals. We have recently extended this critical review to our hospitals in Europe, and the hospitals in Frankfurt and Landstuhl have already received such accreditation.

Our equipment modernization program has also been successful in both the procurement and installation of the latest equipment available to keep up with rapidly changing medical practice and technology.

However, even quality people, modern facilities, and state of the art equipment cannot assure quality medical care. Comprehensive and continuous mechanisms for monitoring such care must and do exist within the Army Medical Department. For example, when a physician reports to a medical treatment facility for duty, he or she undergoes a credentialing process. This is accomplished whether the physician is new in the Army or is a senior officer with many years of experience who is being reassigned to a treatment facility. This credentialing action determines what medical responsibilities and privileges he or she will be granted at that facility.

Furthermore, the physician is also subject to a comprehensive and continuous system that reviews virtually every aspect of medicine that he or she practices throughout the year. For example, utilization review committees periodically audit patient records at random for proper diagnosis and care; and tissue committees audit all tissues, both normal and abnormal, that result from surgical procedures. A multitude of other committees audit all deaths, unimproved cases, complications, infections, transfusions, drug reactions, and many other situations where potential problems can be detected and appropriate action taken or prevention instituted. The establishment and function of these committees are subject to review at least every three years by the Joint Commission on Accreditation for Hospitals and are similarly reviewed through Army Inspector General channels on an alternate year basis.

As an adjunct to these committees and audits, we have a risk management program for lowering the risk of financial loss and preventing hazardous situations. In this program, we appoint a Risk Manager at each facility to be responsible to insure that the local Staff Judge Advocate reviews all unusual occurrences, therapeutic misadventures and medication errors that may result in a claim against the government. We capitalize on this program by having all claims that are filed at the treatment facilities reviewed by The Surgeon General's Consultant in Legal Medicine, to identify patterns and ensure that appropriate followup action is taken.

RESOURCE ACCOUNTABILITY

Resource accountability is ultimately a function of command. It is the Army's control mechanism to insure that resources are expended on those missions tasked to elements of the Army. For the Army Medical Department, various commands are held accountable for resources. For Europe and Korea, the major Army commands are accountable. For CONUS, Panama, and Hawaii, Health Services Command is accountable and for other miscellaneous activities, my office is accountable.

Resources are allocated to the various commands by my office based on Army tasked missions. They are then further distributed to the operating activities based on their individual missions. On a periodic basis, the various Commands receive and provide reports on resource expenditures and manpower utilization from their various activities and the consolidated command reports are received by my office. Then, as necessary, appropriate management actions are taken or resources adjusted.

CONCLUSION

I would like to conclude by stating my commitment to the highest quality of care for the soldier, his or her family and our retirees. A most important goal during my tenure is to further improve both the quality and professionalism of our health care team and, through them, the health care we deliver. I believe an emphasis on regionalization and the better utilization of resources to be one means of accomplishing this. Quality medical care is a part of esprit that affects the morale of our soldiers, and it will insure their maximum performance and survivability on the battlefield as well as in peacetime.

Mr. Chairman, I thank you for the opportunity to appear before this committee.

Senator JEPSEN. Gentlemen, we have some activity on the Senate floor and it requires our presence for approximately the next 20 minutes. We have a vote now that is in its final 3 to 4 minutes. We have a vote that has been long scheduled for 3 o'clock. Then we have another vote which is 10 minutes in length, after the 3 o'clock vote.

So, at 3:20 we should be finished with voting. We will have voted three times in that period. Rather than chop this up, I would just ask your patience and understanding while we recess this subcommittee until 20 minutes after 3.

[Whereupon, a recess was taken.]

Senator NUNN [presiding]. Senator Jepsen is coming back in just a moment, he said to go ahead and get started. I have a few questions I might start with.

I understand that you have completed your statements, is that correct?

Dr. Beary, the recent case of Dr. William Stanford in the Air Force pointed to at least one instance of a serious deficiency in the military medical system in reporting on the credentials of military doctors entering civilian practice.

Are you familiar with that case?

Dr. BEARY. With the general details of it; yes, Senator.

Senator NUNN. I would like to ask you a few questions about that. Have there been any new directives issued by the Secretary of Defense establishing a new policy in the area since that case came along?

Dr. BEARY. Yes, sir. The initial guidance was in the form of a letter so that policy would be available and in force in the interim during the time it takes to get a directive and coordinate it. That policy guidance is in place that requires notification of the credentials problems of a practitioner. The directive is expected to be completed within the next couple of months.

Senator NUNN. So, you have an interim policy in place and you have a directive circulated.

Dr. BEARY. That is right.

Senator NUNN. Are the two one and the same basically?

Dr. BEARY. Basically they are the same and our general counsel, of course, coordinated on the policy letter of March 16 and feels that the Privacy Act considerations and so forth will not be a problem.

So, we anticipate we will be able to take care of the confidentiality and the Privacy Act aspects, and they will be expanded upon in the directive.

Senator NUNN. In other words, that is a problem area but you think it can be overcome.

Dr. BEARY. Surely, it is solvable. It is my understanding the VA has already successfully addressed this problem. My staff is looking into the specifics of their experience as regards the Privacy Act.

Senator NUNN. What does this new directive and the interim policy provide in substance about notifying civilian hospitals on the qualifications of military doctors?

Dr. BEARY. The essence of it is that if a physician is known to have some professional shortcomings, the service is obligated to provide that information. The general guidelines would be, I suppose, to tell the person getting the letter what you would want to know if you were receiving it.

Senator NUNN. Now, is that a voluntary act on the part of the military under this new directive, or is it in compliance with the request for information?

In other words, let us assume that you do not get any inquiry at all about this particular doctor from anybody. What do you do, if there is a problem area?

Dr. BEARY. The obligation rests with the service to inform the gaining facility of appropriate and complete professional information. So, it is not left to the hospital to inquire. Formally, we phrased it in terms of an obligation.

Senator NUNN. An affirmative obligation.

Dr. BEARY. That is corect.

Senator NUNN. Independent of any request for information.

Dr. BEARY. That is right.

Senator NUNN. Let me ask each of the Surgeons General if you would tell us what new procedures your military departments have established to comply with this new policy on notifying the civilian medical community of the qualifications of military doctors. General Myers?

General MYERS. Yes, sir. The Air Force implementation of that directive is almost precisely like the guidance.

Senator NUNN. Is it in effect?

General MYERS. Yes; it is in effect. The implementation has been written. In fact, it has not been applied. We are still waiting for the final clarification on the Privacy Act.

Senator NUNN. So, it has been written but is not yet being implemented until you get final clarification on the Privacy Act?

General MYERS. Yes.

Senator NUNN. When do you expect that?

General MYERS. As soon as we receive the guidance from the Department of Defense.

Senator NUNN. Dr. Beary, when do you expect the final guidance on the Privacy Act?

Dr. BEARY. In the neighborhood of 60 days, I would think, that the final directive should be complete.

Senator NUNN. So, right now, in spite of the fact that you have issued a new directive and an interim policy, and the Air Force has issued a directive in compliance with that DOD directive, it still has not been implemented in terms of policy until such time as you get clarification on the Privacy Act from the DOD legal point of view; is that it?

Dr. BEARY. Well, I would say in the interim it calls for the judgment of the people who are sending a physician to practice somewhere. I think the expectation of Mr. Carlucci's letter was that this would be done now.

Senator NUNN. General Myers, is it being done now?

General MYERS. Sir, the answer is that we were advised that it would be best to wait for a legal clarification so that a person's rights would not be violated.

Senator NUNN. Who advised you of that?

General MYERS. That was guidance we received from our own staff. We were told, of course, on the matter of the Privacy Act implementation, that an explanation would be forthcoming from DOD.

Senator NUNN. So, if you had a real problem area right now an Air Force doctor was going to work for a hospital and you knew there was a problem area, notwithstanding the DOD directive, you would still not take any action at the present time until you get clarification on the Privacy Act?

General MYERS. No, sir. If it was something that we felt the civilian community should be advised about, we would seek the aid from our judge advocate to process it, letting the civilian community have that information.

Senator NUNN. So, you would not ignore the directive, you would take it on a case-by-case basis even before you get clarification on the Privacy Act. You would then ask for judgment on that case from your own counsel.

General MYERS. Precisely, yes, sir.

Senator NUNN. Admiral, could you respond to that same general question?

Admiral COX. Yes, sir, in two categories, if I may. If it is a Navy physician being assigned to a civilian insitution while still on active duty and under our jurisdiction, there would be a complete pro-

fessional review, and there would be full disclosure of any deficiencies in his or her credentials in processing assignments to that position.

If it is a Navy physician who has been released from active duty and is seeking a staff position, should there have been violation of the law and actual judicial action taken against that individual, that information would be supplied.

If it is a matter of questions about the individual's credentials unless we had a request, we would not know whether or what position the individual was seeking. And if we got a request for information we would want a release of information signed by the physician, and then full disclosure would be made.

Senator NUNN. So, let us take a case where you have a problem doctor and you have a clear record that the doctor has had a problem, a real problem area, and there is no request for information. But you know the doctor is going somewhere and he is going to go to work for some hospital or some clinic. What do you do in that case?

Admiral Cox. What I would have to do at the present moment, until there is a clearcut definition of this Privacy Act, is take that on an individual basis, seek legal counsel on my own, and get that information by a legitimate means on a need-to-know basis to that institution.

Senator NUNN. Have you told your people down the line in the Surgeon General operation that they should alert you if there is any case of this nature?

Admiral Cox. Yes. We have accomplished this in the Quality Assurance and Risk Management program with the Credentials Review Committee. If there is any question of competence and its established and that privilege is removed, my office will be notified of that fact.

Senator NUNN. General Mittemeyer?

General MITTEMEYER. Sir, we have in that regard a specific change in our medical record and quality assurance administration regulation which requires every treatment facility commander to report any change in credentialing, any infraction of the code, to the appropriate branch which monitors that health care provider—it could be a physician, it could be a nurse, it could be a medical service officer because they all are health care providers in various areas.

So, each of the career monitoring branches would be notified and in turn the director of the Professional Services, who is a brigadier general and works directly for me, would then monitor that individual.

We would follow the same procedure with regards to a decredentialed physician. I am not sure if the same holds true for the other services, but I believe we are all on the same base.

We now can, on the basis of a withdrawal of clinical privileges, actually separate a physician from the service. This is something that is also a recent change within our Army regulations. This was a bit more difficult procedure in the past. It is one way of fine tuning our medical health care provider corps.

Senator NUNN. General Myers, do you have a procedure for terminating a doctor from the Medical Service?

General MYERS. Yes, sir, we do indeed, Senator. You might be interested in some hard data that we have put together. Between 1979 and 1982 we separated for cause 30 physicians. And we decredentialed over the last 30 months 73 providers, of whom 59 were physicians.

It is interesting to note parenthetically that over 75 percent of those separated were volunteers who had come in from the civilian world. We had, in the majority of cases, extraordinary difficulty in getting information about their problems in the civilian world.

Senator NUNN. From the civilian world.

General MYERS. Yes, sir. They were then brought in. They were not good there. They were not good for us, and we then returned them.

Senator NUNN. So, what you are saying is, it is not a one-way problem. It is not just a problem of the military not notifying civilians, it is also the other side of it.

General MYERS. It seems to be more that way than it is a reflection of our people, who are career people, going out into the civilian world.

Senator NUNN. Mr. Chairman, I went ahead with your permission and started questioning.

Senator JEPSEN. Thank you, Senator Nunn.

Senator NUNN. I have some other questions, but I would rather yield back to you at this point.

Senator JEPSEN [presiding]. Thank you. I want you to continue, but before you leave the quality I have a question in that area. If I may, I would like to ask.

Senator NUNN. Of course, go ahead.

Senator JEPSEN. Admiral Cox, is it true that the National Naval Medical Center was recently cited by the Joint Commission on Hospital Accreditation because of deficiencies in its quality assurance program, and that there is a possibility it might lose its accreditation?

Admiral COX. Mr. Chairman, after the fall of 1981 survey by the survey team of the Joint Commission on Accreditation we were given several months later, tentative notice that there were significant areas of failure of documentation and integration of quality assurance controls.

Additional documentation was supplied to that accrediting body and on that basis they came to a determination that full accreditation would be continued, and that a resurvey would be done by a single physician to make sure that the progress in integration and quality assurance control mechanisms was satisfactory.

That is scheduled to take place on June 28. It is my confident expectation that they will find substantial and proper direction for compliance with those assurance assessments on that date, and when the regularly scheduled resurvey is done in the fall of 1982, that they will be well on track with full compliance for full accreditation.

Senator JEPSEN. Do you know why the Under Secretary of the Navy felt it necessary to put the Inspector General of the Navy in charge of this case?

Admiral COX. He sent out the Navy Inspector General and an ad hoc team of medical experts experienced in JCAH accreditation matters to conduct an assistance visit.

As I understand it, essentially his concern was, how did the so-called flagship of Navy medicine get into these circumstances, and what is it we can do to assist and to make sure that there is no recurrence of this potential threat in the future.

Senator JEPSEN. Thank you. Senator Nunn?

Senator NUNN. Thank you, Mr. Chairman. I have a few more questions but any time you want me to yield back, I will be delighted to

General Myers, according to press reports—and it is my understanding this particular individual case is still going on, the investigation; is that right, the *Stanford* case?

General MYERS. The Air Force Inspector General is still pursuing some data. He will present his reports to the Congress—to Mr. Nichols' subcommittee which tasked him to do them in the first place—very soon.

The part of the investigation which consists of the peer review being done by the Society of Thoracic Surgeons is very complex. It is expected to take a little longer.

Senator NUNN. Would you furnish a copy of that report, after you furnished it to Mr. Nichols, also to this subcommittee?

General MYERS. Yes, sir. I will ask the Inspector General to do so.

[The report follows:]

[The report from the Society of Thoracic Surgeons was not received in time for printing.]

Senator NUNN. With that background I do not want to get into the details of the *Stanford* case. I am sure you would rather avoid getting into a discussion of the details of that case at this point until that report is filed; would you not?

General MYERS. I would not want to usurp any of the Inspector General's findings. But if there are specific questions about the case of which I have rather complete knowledge, I will be more than willing to answer any questions.

Senator NUNN. Well, let me just ask you a few along that line, I will keep them general in nature and wait for the details on that report.

According to press reports, Dr. Stanford had a mortality rate of 43 percent when he was chief heart surgeon at Wilford Hall Medical Center. Is that correct?

General MYERS. That particular statistic appears to be correct for the time period and for some types of cases for which the study was done. That was not Dr. Stanford's total experience. He had been on the staff much longer than that. That was for a 2-year period of time selected out between May of one year and 2 years later. In Dr. Stanford's own data, which was over a different period of time, there was a different mortality rate. Indeed, during the period of my own investigation there were some five sets of data, all of which were dissimilar.

Senator NUNN. Well, let me ask you this general question. Does the Air Force have any prescribed standards for patient mortality rates for doctors practicing in Air Force hospitals in this particular area, that is, heart surgeons?

Do you have anything that you would call the norm, that if statistics get well above that norm it causes sort of a triggering of concern?

General MYERS. I do not think that there is a norm established, Senator. There certainly are some references in literature that give the results of a long series of procedures. But the signal that goes up on any operating service or indeed any health care modes that we may have in any specialty group is the monthly Mortality and Morbidity Committee that tracks the outcome of these given procedures. That is the first signal that something may be off track.

Senator NUNN. Do any of the services have any kind of norm in this area where there are operations that you work against? In other words, what does trigger concern and perhaps review?

Admiral COX. I can answer for the Navy. We have only two centers where this particular procedure is carried out, San Diego and Bethesda. With the professional review of the quality assurance committees, any significant deviation from past experience and acceptable mortality levels would be completely reviewed by that committee, and then in turn by the director of clinical services and the commanding officer.

Senator NUNN. General, do you have any comments?

General MITTEMEYER. Sir, basically no other comments. We have four such centers where that type of surgery is performed and, as has been pointed out by both General Myers and Admiral Cox, we have our postoperative morbidity and mortality committees who review procedures done. Basically, it is an internal review and internal credentialing procedure within the services.

If indeed there is a physician who consistently has bad—I do not want to say "luck"—who has bad results, usually it is his own peers who report that. That is one of the features that General Myers pointed out. We have had within the last year alone 18 physicians noted to be decredentialed, of which 13 were eliminated from the service.

So, there is an ongoing internal credentialing process.

Senator NUNN. Is it a peer review process that is formalized? I will ask that of Dr. Beary. Do you have a DOD requirement for any kind of formalized peer review?

Dr. BEARY. Yes, we do in the sense that the hospitals are required to meet the JCAH standards and the mechanism to address concerns about quality assurance is the credentials committee.

That is central to this issue. The way by which these issues are raised so that the credentials committee can render a decision and say, "Yes, there is a problem," or "No, there is not a problem" is that the health care provider in that hospital—be it a doctor, a nurse—anyone who might have information or concern about the matter can raise the issue with the credentials committee and that committee would assess the evidence and say, "Yes, there is a problem," or "No, there is not a problem."

General MYERS. I would like to add, to kind of round that out, that besides the internal review, the tissue review, and the mortality and morbidity review, there are three agencies which look at those things.

If they see changes, they are very quick to report them. The Inspector General has on his team medical expertise to do that kind of review. About every other year in major facilities the Joint Commission looks at many aspects, including mortality and morbidity rates. One of the most unique ways to identify problems is through the regular reviews by the American board groups who come in to look at residency training programs. They are very careful and you have to provide them with most complete copies of the records of what you have done, how many you have done. And then, in turn, the teachers and the students are interviewed very carefully.

Senator NUNN. Now, you would say at Wilford Hall where this took place there were monthly meetings?

General MYERS. Yes, sir.

Senator NUNN. What do you call it, the monthly——

General MYERS. Morbidity-mortality.

Senator NUNN. Did Dr. Stanford's records come up at any of these meetings?

General MYERS. There was never an identification at any of those meetings until this data was presented. The Joint Commission had been in the previous fall and there was not identification by that group; and the Air Force IG had been in, early in the year, and there was no identification there either.

Senator NUNN. Well, does that tell you that this case demonstrates a need for a tighter review, or are you satisfied with the review that existed then?

General MYERS. No, indeed there is a need for a tighter review and a more regular assessment. What we were faced with were conflicting sets of data which had been lifted out in different periods of time.

I think only the results of the peer review process by the Society of Thoracic Surgeons will give us the final answer.

Senator NUNN. Have you tightened down on the review process now?

General MYERS. Very much so with our quality assurance program prescribed by the Joint Commission, and our risk management program.

Senator NUNN. Are you being personally kept abreast of the IG investigation in this case?

General MYERS. No, sir. I am not.

Senator NUNN. You will get all the results at the end of it, is that the way it works?

General MYERS. The reports will be made known to the Chief of Staff of the United States Air Force and to the subcommittee in the House. I presume that it will be made public and I would have an opportunity to read it.

Senator NUNN. We will probably have other questions at that time.

I would like to put some other questions in the record along this general line for each one of the witnesses, if I could get a response for the record.

General MYERS. You will.

Senator JEPSEN. Thank you, Senator Nunn. We will have questions submitted for your response for the record. We will adjourn this unless the Senator desires to ask any further questions.

I have a couple of questions here. I want to touch on three items that I was hoping we would have a chance to have an exchange of ideas and get some dialog on. One was resource accountability; the other was the quality assurance, and the other was in the area of productivity.

We have talked quite a bit about quality assurance both in specifics and in general, and I would like to comment on the area of resource accountability first. It seems to me that resource accountability is a central issue. I know that malpractice settlements are a drain on the Treasury.

Before I go any further, Dr. Beary, is the number of medical malpractice claims and settlements of concern to you?

Dr. BEARY. Yes, it is, sir. We are conducting a review of the increased filing rate and the increased trend in payouts. We will be addressing corrective actions.

Senator JEPSEN. Does the money come out of the services' pockets or the general Treasury?

Dr. BEARY. Well, it depends, a case can be disposed of in two ways. One would be by settlement out of court in which case it would come out of the service budget; however, if it is sent to the Justice Department for litigation it comes out of the general fund.

Senator JEPSEN. CHAMPUS overruns and medical research and development redundancies present additional problems. Yet, none of these problems seem to be viewed as being relevant to the direct health care system.

An effective risk management quality assurance program could decrease the overall military health care cost to the taxpayer by increasing malpractice claims; is that generally an accurate statement?

Dr. BEARY. It would certainly be our hope by looking at trends and saying, for instance, last year you paid claims on several cases to do with anoxic damage to an infant at birth, or failure to diagnose meningitis in the emergency room—which is a frequent case that one sees in a malpractice setting—that then one could, if you saw where you were having your biggest problems in an area like failure to diagnose meningitis, you could then take appropriate corrective and educational actions to make your health care providers aware that this is a tricky area and that you better pay more attention to this when you evaluate a patient with a headache and fever, so you do not send these people out.

Senator JEPSEN. Increased direct care system productivity could decrease CHAMPUS overruns. Elimination of R. & D. redundancies could save resources which could be used to improve productivity. Yet, there appear to be very few real incentives to gain these management economics, which leads me to this question.

Dr. Beary, title X charges you with the overall supervisions of health affairs of the Department of Defense. Are you in fact personally accountable for the health care resource management in the Department of Defense?

Dr. BEARY. Well, sir, in the sense that I am the principal staff adviser to the Secretary of Defense. However, it is a staff position. The Surgeons General actually distribute the resources themselves.

Senator JEPSEN. Well, can you supervise and be responsible for military medicine if you are not accountable for the resources?

Dr. BEARY. Well, we have addressed that area and feel that we can make substantial improvements through rehabilitation of the regionalization system. I have had good commitments from each of the Surgeons General to give that matter their personal attention and to work vigorously to get more management oversight of the regional health system.

Senator JEPSEN. Would separate medical appropriations improve resource allocation and accountability in the areas of inpatient and outpatient direct health care and military operational support for training and R. & D.?

Dr. BEARY. Well, it would certainly give visibility to the medical budget. However, these budgets are made up by each service. The Army and the Air Force get their funds through major commands. Admiral Cox has a slightly different system, and so forth. So, it would be a rather complex undertaking, Senator, to have three separate medical appropriations.

Senator JEPSEN. Excuse me, who is presently personally accountable for each of these areas in the military departments?

Dr. BEARY. The Surgeon General of each service would be the one with resource accountability. My job is more policy accountability as it is set up.

Senator JEPSEN. Well, then, would the Surgeons General please provide for the record descriptions as of your departmental health resource management information systems and how you use them to contain costs and to assure quality in both the direct and indirect care systems.

[The information follows:]

DEPARTMENTAL HEALTH RESOURCE MANAGEMENT INFORMATION SYSTEMS

ARMY

Cost control in the direct care system is a function of several diverse areas on the Army staff. The Army Comptroller allocates funds to the various Commands based on Army missions and The Surgeon General's recommendations. The Deputy Chief of Staff for Personnel also allocates manpower to the various Commands based on Army missions and The Surgeon General's recommendation. Each year, OSD reviews and approves the AMEDD budget request for both funds and manpower. The various commands have direct control over two appropriations and indirect control over three appropriations. Direct control is exercised over operation and maintenance (OMA) funds and other procurement (OPA) funds. OMA funds provide for civilian pay and other daily operating costs of the direct care system while OPA buys much of the equipment. Indirect control is exercised over military pay (MPA) military construction (MCA) and reserve personnel (RPA). These funds are not allocated directly to the Commands but control is exercised centrally. Commands, however, may take management actions that will alter the funding required.

Once OMA and OPA are allocated to the various Commands, they are further allocated to the operating activities based on individual missions. On a periodic basis, the Commands receive and provide reports on resource utilization and appropriate actions taken by the Commands or Army staff with recommendations from The Surgeon General.

NAVY

The Navy Medical Department has many systems which provide management data and which are used to assist in cost containment and quality control. Some of the systems and reports currently in use are:

Workload Reporting System—provides data by admissions, occupied beds, length of patient stay, births, discharges, outpatient and inpatient visits, limited services, and ancillary services.

Activity Budgets—provide detailed cost data by program showing current year cost, the activity requirements for the budget year, and justification for changes.

Activity Financial Plans—provides detailed cost data on how the funds provided to an activity are planned to be used during the year.

Navy Cost Accounting Systems—provides displays of activity costs by types of expenditures such as: travel, central supply, medical service, etc.

Uniform Chart of Accounts—provides costs of performing work by each professional service and ancillary service. Allows comparison with other activities.

Navy Manpower Reporting System—provides authorized and available manpower data by type of personnel, and projections on-board by month.

SHORSTAMPS—provides manpower requirements to meet specific workload by department.

Uniform Staffing Methodology—provides tri-service staffing standards for medical functions.

CHAMPUS Cost Data System—provides data on both inpatient and outpatient costs for civilian care by area, category of patent and diagnosis.

CHAMPUS Non-availability Reporting System—provides reasons for not providing care in Navy hospitals and medical centers by category of patient.

Beneficiary Population System—provides current and projected population data by category of personnel for use in projecting requirements for medical care in each facility.

Quality Assurance/Risk Management System—provides reports on quality and appropriateness of care at each facility, and results of patient satisfaction surveys.

All of these systems and numerous subsystems and reports are used to assess the internal operation of facilities in terms of cost effectiveness and quality of care. In the resource control area, monthly and quarterly cost reports are compared to the annual financial plan and variances are reviewed to determine cause. A midyear review is held at headquarters to make funding adjustments as necessitated by changing conditions, performance, etc. Unusual requirements are handled on an individual basis.

Quality control is a continuous process. Each patient care activity has numerous committees, infection surveillance personnel, and reports as directed by the Navy Risk Management/Quality Assurance Manual. In addition, the Navy Medical Inspector General and the Joint Council on Accreditation of Hospitals police the system to ensure compliance.

AIR FORCE

The Air Force Medical Service does not have a single, distinct health resource management information system whose primary purpose is cost containment or quality assurance per se. However, various automated and manual information systems do exist which support medical decision-making to include, but not limited to, cost containment and quality assurance. These systems and their usage are as follows:

a. Automated Inpatient Data System—assists in provider credentialing decisions and highlights treatment complications and excessive lengths of patient hospitalization.

b. Dental Service Reporting System—assists in evaluating dental care provided and forecasting resource requirements.

c. Defense Enrollment Eligibility Reporting System—provides demographic characteristics on beneficiaries served, assists in resource allocation decisions, and reduces fraud and misuse of medical benefits through determination of patient eligibility status.

d. Facilities Planning Model—assists in determination of health facility construction requirements.

e. Medical Education Program—provides a consolidated data base of education and training as a reference for determination of fiscal, manpower, and logistical support requirements.

f. Medical Material Management System—provides a comprehensive tool for total management of medical supplies and equipment.

g. Provider Requirements Integrated Specialty Model—used to forecast and allocate providers through determination of the quantity and specialty mix required under various scenarios (under development).

h. Report of Patients—provides patient workload and related data to support a multitude of medical resource planning and allocation decisions in such areas as budgeting, staffing, construction, equipment, and opening/closing clinic services.

i. Uniform Chart of Accounts—provides medical expense and performance data which can assist in cost containment decisions on a facility specific basis.

j. Uniform Staffing Methodologies—provides manpower utilization data for the determination and justification of medical facility staffing requirements. (partially implemented)

k. Tri-Service Patient Appointment and Scheduling System—automates patient appointments, provider scheduling, and workload data collection. (partially implemented)

l. Tri-Service Patient Administration System—automates patient admission and disposition, clinical records, and patient billing functions. (partially implemented)

m. Tri-Service Pharmacy Initial Operational Capability System—automates pharmacy activities and assists in drug inventory management, medication screening, and dated-item control, (partially implemented)

n. Tri-Laboratory and Tri-Radiology Systems—provide automated support to improve functional efficiency in these two clinical service areas. (partially implemented)

The above systems, singly and in combination, assist management in the efficient and effective utilization of medical resources, the containment of costs, and the provision of quality health care.

Senator Inouye mentioned the fact—he was talking about CHAMPUS—he referred to a situation which is not too atypical of the Washington area here. We have a number of medical facilities. I suppose if you count on a major basis we are talking about what, five—without enumerating them—something in that area?

Dr. BEARY. The Washington Metro area?

Senator JEPSEN. Yes.

Dr. BEARY. Five, yes.

Senator JEPSEN. Something like that. And yet, we had CHAMPUS, as I understand it, in this metro area costing $15 million last year.

Dr. BEARY. Well, $15 to $17 million.

Senator JEPSEN. How do you explain that? We have Walter Reed and I think the admiral referred to the "Flag Hospital" of health care services in Bethesda, and so on; and $17 million for CHAMPUS?

Dr. BEARY. Well, we are just getting an information system into place to let us make a meaningful comment on those matters.

We have the feeling that most of this money is spent for obstetrics and psychiatry. So, it would seem that we would take some action among ourselves to certainly put a lot of the obstetric work back in-house in the sense that these people who have wartime surgical skills could be cross-trained to do other things and keep the business in the direct care system.

Senator JEPSEN. We will adjourn this meeting. I delegate Mr. Principi, he can pound the gavel. He has one question. We have a number that would pertain to this in both the areas of productivity and accountability.

I will just take a second to express my appreciation to you, General Myers. I understand you are about to retire; is that correct?

General MYERS. Yes, sir.

Senator JEPSEN. I wish the record to show that I extend to you my appreciation and gratitude for the many years of service and the numerous innovative contributions made by you toward quality health care for military personnel. Your "Red Flag" exercises to improve medical readiness training will stand as living testimony to the creative commitment that has marked your distinguished military career, and our Nation is indebted to you.

I thank you for your many years of dedicated service to this beloved United States of America.

General MYERS. I appreciate your comments, Mr. Chairman. Thank you very much.

Senator JEPSEN. Thank you.

Mr. PRINCIPI. I can submit my questions for the record, gentlemen. I think perhaps we should adjourn. Thank you very much.

[Questions with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR ROGER W. JEPSEN

LINES OF AUTHORITY

Senator JEPSEN. Gentlemen, are lines of authority drawn by your health care regions, or do they follow Service command channels?

ARMY

General MITTEMEYER. Lines of authority for the provision of health services are established for the Army by Army Regulations and follow command channels. However, the Army, in conjunction with the Air Force and Navy, has established a joint regulation providing for the review of high cost medical equipment on a DOD regional basis. Health facility requirements for medical equipment costing more than $200,000 are forwarded to the appropriate Regional Review Committee for concurrence or nonconcurrence based on the total need within the region for the requested item. This decision with supporting rationale is then evaluated by the Military Medical Regions Task Group for any other Tri-Service implications. This organization makes a formal recommendation to the Defense Health Council which is the final authority on procurement.

NAVY

Admiral COX. Within Navy medical regions, the lines of authority start with the regional commanding officer who has total responsibility for all personnel and funds allocated by the Chief of the Bureau of Medicine and Surgery for the operation of the region. Naval Hospitals, Regional Medical Clinics, and Branch Clinics report directly to the regional commander. Commanding officers of regions and subordinate commands have additional duty to the line commanding officer.

AIR FORCE

General MYERS. Within the Air Force, lines of authority follow command channels. This arrangement stems from the organizational principle that the Air Force wing is the pivotal Air Force unit and is the single unit capable of indefinite self-sufficiency. The wing organizational concept is the classical line and staff with all base resources under command and control of the wing. This is fundamental to the Air Force philosophy of organizing in peace in preparation for war. The medical treatment facility (MTF) commander reports directly to the wing commander. As such, the MTF commander has organic staff activities which supplement but do not duplicate other specialized staff—comptroller, administration, civil engineers, etc. He draws upon those other agencies for comprehensive specialized support. This organization philosophy is carried through at all levels of Air Force management. Major Command surgeons and the Air Force Surgeon General are special staff activities that provide advice and counsel to Air Force major command commanders and the Chief of Staff, respectively.

RESOURCE ACCOUNTABILITY

Senator JEPSEN. Is resource accountability structured by region or by command lines?

ARMY

General MITTEMEYER. Accountability follows the lines of authority as previously noted. To insure the effective accomplishment of the mission of the Army, responsibility, authority, and accountability follow command channels.

NAVY

Admiral COX. Resource accountability in the Navy Medical Department is structured by region. Only one operating budget is issued by me to each region. This allows the regional commander to provide for each clinic the funds required to meet the needs of the fleet units supported, making necessary adjustments as operational units arrive and depart.

AIR FORCE

General MYERS. Resource accountability in the Air Force is structured by command lines from each individual wing or installation commander (to whom

medical facility commanders report) to major commands (where the major command surgeons review and validate medical resources requirements) to Headquarters USAF (where the Air Force Surgeon General's office also reviews and validates requirements). This structure insures that each medical facility commander receives funding from the same source that directs the mission.

ACCOUNTABILITY FOR LOW UTILIZATION RATE

Senator JEPSEN. Could an Army regional commander hold an Air Force hospital commander accountable for a low utilization rate or an inappropriate request for major equipment?

ARMY

General MITTEMEYER. An Army commander within a DOD Region cannot hold an Air Force hospital commander accountable for a low utilization rate. However, the Armed Forces Regional Health Services System provides a mechanism whereby a member of the Military Regional Review Committee can formally communicate concerns about the provision of services within the region to the chain of command of the facility concerned. This mechanism takes the form of a quarterly report forwarded to the Military Medical Regions Task Group and each Surgeon General. Issues not resolved by the regional committee will be acted upon by representatives of the three Surgeons General who comprise the Military Medical Regions Task Group. If the task group cannot reach an agreement which is satisfactory to the Services involved, the issue is forwarded to the Defense Health Council for final adjudication. In those instances involving the procurement of major medical equipment, the procedures have been formalized with the publication of a joint regulation.

NAVY

Admiral Cox. Accountability in a legal sense, no. But at a Tri-Service Regional Coordinating Committee meeting, any member may raise an issue, whether one of productivity or need for major equipment. These are recorded in the minutes and forwarded to the Assistant Secretary of Defense (Health Affairs) and the services. In the case of major equipment purchases, they must also be approved by the Defense Health Council.

AIR FORCE

General MYERS. No. The Air Force hospital commander is directly accountable to the Air Force line commander in charge of the unit the hospital supports. However, utilization rates are often discussed at regional meetings. Utilization of specialized services and equipment is often a major item of discussion at regional meetings. Equipment with a unit cost in excess of $200,000 must be approved by the DOD regional committee and must also be approved by the tri-service DOD Health Council.

TRANSFERRING O. & M. DOLLARS

Chairman JEPSEN. Admiral Cox, if any Air Force hospital has a shortfall of O. & M. dollars and a Navy hospital in the same region has a surplus, could the Navy commander transfer the necessary funds?

Admiral Cox. I am not aware of a situation where any Navy hospital had a surplus of funds. However, on a theoretical basis there are mechanisms where funds could be made available to the Air Force, but it must be made via command channels and not by the local commander.

HEALTH BUDGET

Senator JEPSEN. We have read and been told a great deal about regionalization of the Military Health Care System. Yet what seems to exist are three separate, somewhat regionalized systems. Is the health budget tied to population served?

ARMY

General MITTEMEYER. Yes. Population estimates based on current demographic trends at supported installations, together with known future events such as mission changes and force structure increases or decreases, are two bases for developing workload projections. They are examined by beneficiary category.

Funding levels are determined by application of past cost experience adjusted for changes such as advancing medical and dental technology, OSHA, facility and accreditation requirements, and improvements in training programs necessary to support the Army's readiness posture.

NAVY

Admiral Cox. The Navy medical budget to Congress must first support the primary mission of the medical department: to be prepared to support the wartime requirements of the Navy and Marine Corps. Portions of the budget which are based upon peacetime health care for retirees and dependents are based upon population supported.

AIR FORCE

General MYERS. Yes. The Air Force health budget is tied to the beneficiary population served by the Air Force Medical Service. Individual medical facility budgets, as well as the overall medical service budget, are based on the workload generated by the beneficiary population served. These budgets reflect changes in that population both at individual installations and Air Force wide. Under the regional hospital/area medical center concept employed by the Air Force, patients are referred to tertiary care facilities for more definitive care. All patient transfers, including those from other Service medical facilities, are considered when budgets are developed.

CAPITATION BUDGETING TEST FAILURE

Senator JEPSEN. Is it not true that the capitation budgeting test failed because you attempted to superimpose one resource allocation system on top of the existing structure without altering lines of authority and resource accountability?

ARMY

General MITTEMEYER. The capitation budgeting test was not a failure. The test was designed to determine if a particular budgeting concept, successfully applied in some portions of the private health sector, would induce improvements in the provision of health services and utilization within the Military Health Services System while lowering total government costs. The test demonstrated that the budget methodology employed, per se, did not promote accomplishment of these objectives any better than did conventional budgeting procedures. The test also demonstrated that the management flexibilities afforded commanders of participating health facilities, such as integration of CHAMPUS and Operation and Maintenance funds, coupled with removal of civilian end strength limitations, deserve additional consideration as they indicate potential for improved operations with any budgeting methodology.

The imposition of an OSD-directed and controlled committee system to determine resource requirements, and to make allocation decisions for a DOD Region collectively, occurred in one of two regions participating in the test. This experimental regional funding arrangement proved unsuccessful. It violated basic management principles by separating the source of missions (Services) from the source of funds (OSD). However, it is important that this attempt to regionalize funding not be confused with either capiration budgeting or the continuing cooperative interchanges occurring among federal facilities within the nine DOD Regions.

NAVY

Admiral Cox. No, I do not believe that to be true. In DOD Region I, the Northwest, where the Tri-Service test was conducted, the Tri-Service Regional Committee had total control of resource allocations for the Army, Navy and Air Force facilities involved. Once they determined the distribution of funds, they were distributed through service channels for accounting purposes, but the regional committee could adjust or transfer funds between activities as they saw fit, thus providing resource accountability.

AIR FORCE

General MYERS. No. A test of a regional resource budgeting and allocation system in DOD Medical Region 1 (Pacific Northwest) was added after two years of Capitation Budget testing. The regional test was not required to test Capitation

Budgeting. Therefore, it did not impact on the results of the test of Capitation Budgeting. The Capitation Budgeting test did not fail. Rather, as the word test implies, Capitation Budgeting was evaluated and not implemented because it did not offer significant improvements over the current Planning, Programming and Budgeting System (PPBS).

MANAGEMENT OF REGIONAL MANAGERS

Senator JEPSEN. If you established regionalized lines of authority and accountability, how would you manage the regional managers?

ARMY

General MITTEMEYER. The foremost responsibility of the Army Medical Department is to be prepared to support the Army in wartime and provide health services support to the soldier and his family in peacetime. As mentioned earlier, the establishment of responsibility, authority, and accountability within our system has been done to support this mission. Any consideration of changing the lines of authority and accountability within our system connotes a change to the primary responsibilities of each of the military departments. The Armed Forces Regional Health Services System provides an appropriate framework for review and oversight of health resources utilization, but is not an acceptable substitute for command and control over Service mission-oriented organizations and resources.

NAVY

Admiral COX. I currently operate a regionalized system of health care. The system is oriented to provide support first to the Navy and Marine Corps operating forces, second to the active duty members of all the Uniformed Services, and finally to other eligibles on a space available basis as provided for by the Congress. Authority is provided my regional managers through me, but accountability is to the operational commanders as well as myself.

AIR FORCE

General MYERS. The current established lines of authority and accountability within the Air Force and the Medical Service have proven successful both in terms of mission accomplishment and resource management. The Air Force and its Medical Service continue to believe that these lines of authority and accountability should not be altered. Therefore, no recommendations relating to the management of regional managers are offered.

PUBLIC LAW 97–174

Senator JEPSEN. Do you think that P.L. 97–174, the VA–DOD Health Resources Sharing and Emergency Operations Act, will significantly improve sharing within the Federal health system?

ARMY

General MITTEMEYER. The Army Medical Department is very optimistic about the service and resource benefits which can result from this legislation. With the obstacles to the use of VA facilities removed, our hospital commanders will now have a full range of economic alternatives available in securing services for their beneficiary population. In addition, the reimbursement provisions of the law will provide an incentive to our commanders to share excess capacity in military facilities with local Veterans Administration beneficiaries. We feel that the quality and quantity of care will be improved to both the VA and DOD beneficiary population with the increased access, particularly in the more highly specialized services. We also feel that the cost of sharing these services will in many instances be considerably less than procuring them from non-Federal sources or moving our patients to another military treatment facility. We look forward to working with the Veterans Administration in developing the guidelines for implementation of the law.

NAVY

Admiral COX. The implementation plan for this legislation is being developed. The resulting actions are anticipated to promote progress action toward improved health system sharing. Current efforts are being taken through the Fed-

eral Health Resources Sharing Committee to better assess current sharing programs and identify further opportunities for sharing Federal health resources.

AIR FORCE

General MYERS. Yes. There will be improvements in sharing and reimbursement procedures by mutually negotiated agreements among DOD and VA facilities at the local level. Further, the law allows for VA care to Armed Forces during wartime or national emergency.

UTILIZATION OF MILITARY HOSPITALS

Senator JEPSEN. Let's leave the resource accountability issue and move to another key management criteria—productivity. The CHAMPUS Program is experiencing tremendous growth in costs, yet the DOD beneficiary population is relatively stable. The rising costs of hospital care in the civilian sector don't, by themselves, explain the increased CHAMPUS costs. Furthermore, as the numbers of military physicians and support personnel have increased, the utilization of military hospitals has declined. These facts are understandably quite puzzling to us. How do you explain the decrease in utilization of military hospitals?

ARMY

General MITTEMEYER. Utilization of Army treatment facilities in terms of care provided has increased from a fiscal year 1977 level of 36,565 average daily Medical Care Composite Units (MCCU) to a 1981 level of 38,074. Fiscal years 1978 and 1979 experienced a slight drop which is attributable to the physician shortage. However, workload began increasing as the physician strength improved.

NAVY

Admiral Cox. Utilization in Navy hospitals has been increasing for the past two years. Utilization is best measured by admissions. In the Navy, admissions were gradually decreasing from 1976 to 1979 as a result of our shortage of physicians and then started increasing again in fiscal year 1980 as our recovery began. In 1981, we were back to the mid-seventies level. This is borne out by the decreased issuance of non-availability authorization for CHAMPUS, which dropped 5,308, or 17.7 percent between fiscal year 1979 and 1981.

AIR FORCE

General MYERS. There are a number of contributing factors that have impacted on utilization of Air Force medical facilities. The foremost problem has been that of severe shortages of assigned specialists which caused closures of entire services at many bases. Those specialties, i.e., General Surgery, Orthopedics and Obstetrics, are also the ones that traditionally generate a substantial number of bed days and follow-up visits. Furthermore, for the last six years our largest medical center has been undergoing a major construction program that has significantly impacted potential workload capacity. The disruption at this single 1000 bed facility accounts for 80 percent of the decrease in admissions for the Air Force. We have received additional manpower authorizations only recently—and we appreciate your support in this regard—but in actuality we are just beginning to realize an increase in assigned personnel available to provide direct patient care due to the normal lag time associated with recruiting and training accessions. Another prime contributor is that of inadequate support personnel. Our ratio of support personnel per provider actually fell each year from fiscal year 1977 to fiscal year 1981. We turned the corner in fiscal year 1982 when the ratio increased from 1.5:1 to 1.64:1 in the ambulatory care clinics. Other factors relate to intensified readiness training requirements and a migration and concentration of many retired beneficiaries in areas where facilities cannot accommodate them. Also, more time is being devoted to health education and preventive medicine with less emphasis on hospitalization and clinic treatment. We have been very successful with these programs to improve the health status of our beneficiaries, as evidenced by the noneffectiveness rate—the time lost from the job due to illness—which is now the lowest in Air Force history. The decline in utilization rates that we have experienced in recent years has now stopped.

Preliminary data for the first quarter of this calendar year reveals modest increases in both admissions and outpatient visits compared to the same period last year. Future utilization rates are expected to continue to increase as we reopen services we had to close because of physician shortages.

MONITOR ACCESSIBILITY AND PATIENT SATISFACTION OR DISSATISFACTION

Senator JEPSEN. How do you monitor accessibility and patient satisfaction or dissatisfaction with your services?

ARMY

General MITTEMEYER. There are presently four major means of collecting data within MTF to identify, define, and resolve consumer concerns. First, Patient Representatives are assigned at each facility to assist patients in resolving problems which arise within the facility. Generally, these representatives have direct access to the MTF commander and are tasked to inform him of major areas of concern. Inspector General personnel perform a similar function by keeping the commander informed of trends in patient complaints and identifying potential problem areas. Additionally, each facility conducts an annual patient satisfaction survey, the results of which are reviewed and utilized to identify and correct areas of concern. Finally, each MTF has established a Health Consumer Committee which offers another opportunity for consumers to provide comments and a method to have their views considered in the decision making process.

NAVY

Admiral Cox. In May of 1981, I directed each medical center, hospital and clinic to establish a patient satisfaction information system to assess the level of satisfaction with health care provided. Components of this information system include semi-annual patient satisfaction surveys directed towards inpatients and outpatients, review and analysis of incident reports and patient complaints, and a consumer council composed of ombudsmen from each command in a commanding officer's area. Standardized report formats are provided for use at the command level. Incident reports assist with problem detection, resolution, and correction monitoring. Semi-annual summaries of command input are reviewed by the Bureau each January and July. Commanding officers also receive input from wives clubs, and retired groups; Fleet Liaison Officers, who are the contact point for all ships; and of course, letters and personal communications of praise and complaints. My Inspectors General both medical and dental, review command efforts to monitor patient satisfaction during their biennial inspections. In addition, they also visit with each subordinate command and solicit the commanding officer's opinion of medical and dental support. The Inspectors General then report directly to me.

AIR FORCE

General MYERS. Numerous mechanisms are currently utilized by the Air Force Medical Service to monitor accessibility and patient satisfaction or dissatisfaction with health care. These include formal recurring mechanisms such as the Risk Management Program, Health Consumer Advisory Council, Inspector General Inspections, Major Command Staff Assistance visits, reviews by external agencies such as the Joint Commission on Accreditation of Hospitals and Base Advisory Councils. Satisfaction and accessibility are also evaluated through questionnaires utilized by the Air Force Inspector General, Air Force Surgeon General's Office, the Military Manpower and Personnel Center, and local medical treatment facilities.

In addition to the aforementioned mechanisms, Inspector General findings, Inspector General complaints, and Medical Congressional inquiries are reviewed and analyzed to reveal areas requiring corrective action.

FAIR SHARE OF PARENT SERVICES RESOURCES

Senator JEPSEN. Do the Medical Services get their fair share of the parent Service's resources?

ARMY

General MITTEMEYER. The resources provided to operate health services in the Army are considered a fair share of the Army's overall resource capability.

NAVY

Admiral Cox. The Navy budget is constructed on a programmatic basis; the Navy Medical Department is no exception. In recent years, shortfalls in military medical manpower and supporting operations and maintenance funding have been alleviated by modest increases, even though overall Navy requirements exceeded resource availability. In essence, all segments of the Navy budget, including medical, reflect prioritization of requirements. It is evident the Medical Department currently enjoys a high priority within the Navy, both from the standpoint of increasing medical contingency response capability and the resultant decreased dependence on the CHAMPUS program.

AIR FORCE

General MYERS. Yes, within the limited total dollars provided to the Air Force. The Air Force Board Structure utilizes the DOD Planning, Programming and Budgeting System (PPBS) to review and validate all resource requirements for the Air Force, including manpower and facilities. Under this system, fiscal constraints are allocated equitably among the various missions of the Air Force.

INCREASE IN MEDICAL SUPPORT

Senator JEPSEN. General Mittemeyer, in fiscal year 1981, each service was given a substantial increase in medical support personnel authorizations. Did the Army Medical Department realize that increase?

ARMY

General MITTEMEYER. The Army realized an increase of 230 civilian and 46 enlisted medical support authorizations beginning in fiscal year 1981.

INCREASED CHAMPUS COSTS

Senator JEPSEN. Gentlemen, how do you account for the increased CHAMPUS costs, especially in light of Dr. Beary's statement that 75 percent of CHAMPUS dollars are spent in military catchment areas?

ARMY

General MITTEMEYER. Dr. Beary has advised us that while 75 percent of CHAMPUS dollars are spent with civilian providers located in military catchment areas, only 55 percent of all CHAMPUS costs are incurred for care of beneficiaries who actually live in those catchment areas. It is therefore assumed that at least some portion of the cost is incurred by beneficiaries, living more than 40 miles from the nearest Armed Forces medical treatment facility, who obtain civilian care from providers located just across the catchment boundary.

While we are currently unable to account for the large increase in CHAMPUS costs, the matter is under study. We do know that the number of inpatient care nonavailability certificates issued by Army medical treatment facilities during fiscal years 1979–81 has remained relatively static. If current fiscal year 1982 data continues at its present rate, the number of such certificates issued for fiscal year 1982 will likely decline by approximately 5,000 below the fiscal year 1981 level. Accordingly, we are led to believe that the overall increase in CHAMPUS costs represents the cumulative effects of numerous factors including:

Inflationary forces within the civilian health care sector of approximately 23 percent.

Increased use of the "freedom of choice" option by CHAMPUS beneficiaries, allowing them to obtain civilian outpatient care without first obtaining certificates of nonavailability.

A possible increase in the number of retirees within the beneficiary population.

A possible shift in the number of beneficiaries living beyond the boundaries of the catchment areas.

Reduction of the catchment area from 40 miles to 30 miles for purposes of obtaining maternity care.

NAVY

Admiral Cox. CHAMPUS costs increase for a variety of reasons. Inflation, expansion of authorized benefits, better information to beneficiaries about available benefits, co-insurance by retired groups, more sophisticated medical tech-

niques and equipment, and an older average age of beneficiaries all contribute to rising costs. In reviewing cost increases it is important to keep in mind the decision to use CHAMPUS for outpatient care is a personal choice made by the beneficiary. Furthermore, some services, such as psychiatric inpatient care, are available only to active duty in military facilities. Since the majority of our population eligible for CHAMPUS is located around our military bases and hospitals, most of our CHAMPUS workload occurs in those areas. It should be noted that the issuance of non-availability slips at Navy medical facilities has decreased from 30,072 in fiscal year 1979 to 24,764 in fiscal year 1981.

AIR FORCE

General MYERS. It is our observation that the increase in CHAMPUS costs results from general inflation in health care, the geographic dispersion of the beneficiary population and the increased intensity of care required by an aging retired population, including their dependents. Further, additional costs are associated with CHAMPUS methodology improvements in calculating allowable charges and reimbursements.

The high proportion of CHAMPUS costs that occur within medical catchment areas results from clustering of beneficiaries around select military treatment facilities that are inadequately sized and staffed to meet the beneficiary population health care needs. Sizing is based upon uniform criteria that relates to active duty and active duty dependent workloads, plus five percent for non-teaching facilities and 10 percent for facilities with teaching and training requirements. Therefore, facility sizing does not allow for a significant portion of the beneficiary population. This leads to a large disparity between care available in the military treatment facilities and care required by the beneficiaries.

In the Air Force, 74 percent of the nonavailability statements issued in FY81 were because services were not available in the local military medical treatment facility. Sizing and staffing the facility to support the readiness mission will result in increased resources for the direct care system and a subsequent reduction of CHAMPUS costs. Numerous previous studies, as well as current data from the Uniform Chart of Accounts, show the direct care system to be more cost-effective than CHAMPUS.

IMPROVED PRODUCTIVITY IN DIRECT CARE COSTS

Senator JEPSEN. What actions have you taken to improve productivity in the direct care system?

ARMY

General MITTEMEYER. Improving productivity, that is, providing health care to more beneficiaries without degradation of quality, continues to be a primary management objective of the Army Medical Department. We are presently in the implementation phase of the new, Tri-Service Uniform Staffing Methodology which will increase our ability to match both long and short term manpower requirements, to include skill mix and grade levels, with health care demand presented by the beneficiary population. Also, we continue to adapt automatic data processing technology to both clinical medicine and clinical support.

Three years ago the Army Dental Care Delivery System established a management improvement program that focused on enhancing the effectiveness and efficiency with which dental care was provided to eligible beneficiaries. The concept included redistribution of manpower assets, development of an improved workload measurement program, establishment of a goal oriented incentive system, and a review and analysis initiative to assist top level decision makers. To date, without any additional assets, that program has resulted in increased productivity by 9 percent over fiscal year 1981.

We have also increased our medical productivity. Our average length of patient stay time has decreased, thereby reducing the number of non-effective days for active duty personnel. The continuing decline in our active duty non-effective rate (personnel excused from duty per 1,000 strength) attests to our achieving this objective. It has declined some 23 percent since 1975, the first year all RVN casualties were out of our direct health care system. Our efforts to modernize facilities have also contributed to improved productivity. However, persisting shortages in "blocking" specialties such as general and orthopedic surgery, anesthesiologists and OB/GYN as well as ancillary support personnel continue as severely limiting factors to continued productivity improvement.

NAVY

Admiral Cox. I have made it clear to my commanding officers that improved productivity is one of my primary goals. The emphasis I have placed on productivity has resulted in an increase in workload and a decrease in the number of CHAMPUS non-availability authorizations. Specific steps I am taking to effect further improvements include increasing ancillary support to our physicians by distributing programmed manpower increases to this area, improving the facilities, and providing modern equipment.

AIR FORCE

General Myers. We have taken a number of actions, the first ones being to determine the major factors that impact on productivity. The most significant factors are adequate facilities and support personnel. We conduct comprehensive reviews of manpower standards to ensure they provide sufficient provider support personnel and strive to provide more examination and treatment space for our providers through new construction, alterations, and additions to our medical facilities. Where facilities and equipment permit, we are practicing two-chair dentistry. We are purchasing modern equipment, some of it through the Air Force Productivity Enhancement Programs, which permit us to perform in-house work that until recently was done at high cost from civilian sources. Some of the more visible examples are endoscopy, CT scanning and sonography equipment. As more specialists complete training and enter the work force, we are concentrating on placing them and support personnel at facilities where we had to close services several years ago. We actively participate in the Air Force Productivity Program, providing detailed crossfeed information to all command surgeons. They in turn provide appropriate guidance to their facilities.

INCENTIVES FOR GOOD MANAGEMENT

Senator Jepsen. What tangible incentives are there for good management in the system?

ARMY

General Mittemeyer. The most important incentive for good management is the performance appraisal system which rewards good management with good performance ratings. The ratings are vital to an officers career for advancement, promotion and retention. With a selection rate well below 50 percent for promotion to Colonel, it is very competitive and incentives for good management and job performance are significant. The Army has other tangible incentives in our system. Our system tends to focus on the organization rather than on individuals. For example, the Army's Economies, Efficiencies and Management Improvement Program allows the savings for managerial actions to be retained by the field organization to be used to meet unfunded requirements. Additionally, there are incentives within the resource allocation system that have become "institutionalized". For example, resources to support capital investment equipment, continuing education, etc. are allocated primarily on the basis of need but also on the basis of demonstrated performance. One area where the individual can benefit is the Army Suggestion Program where a cash award is made to the individual on the basis of the magnitude of his/her suggestion in terms of dollar savings to the government.

NAVY

Admiral Cox. Admittedly, the military does not have the "carrot" that exists in civilian health care—increased salary and other incentives. However, each commanding officer has the ability to reward effective management of his subordinates through increased opportunities for professional development, through funding of equipment items which would enable the capable manager to recapture more workload, and through fitness report evaluations which determine an individual's advancement in the Navy. The commanding officer who is a good manager is rewarded by selection for advancement and increase responsibility in subsequent assignments.

AIR FORCE

General Myers. The word tangible has significantly different meaning to different people. In our business of keeping people well and healing the sick, a very powerful and tangible incentive—which may be unique to medicine—is that of

improving the overall health of our people. This has been done and is confirmed by the steady, continuing decline of time lost from the job due to illness. That is and always has been the basic goal of our profession. Other highly visible incentives are promotions and assignments to higher levels of responsibility. Many of our people have also received cash awards for innovative ideas through the Air Force Suggestion Program. Commands compete for the Medical Service's Project KEEP trophy, awarded annually for the highest rate of retention of physicians.

INDUSTRIAL FUNDED CHAMPUS

Senator JEPSEN. If we industrially funded CHAMPUS, and then each military hospital had to reimburse CHAMPUS for care provided to beneficiaries in its areas, wouldn't that provide a powerful incentive to increase direct care system productivity?

ARMY

General MITTEMEYER. Industrial funding of CHAMPUS is really a variation of one thrust of the now-terminated capitation budgeting test. Medical treatment facility commanders were provided CHAMPUS funds and were held financially responsible for care provided to their entire beneficiary population (within that facility's 40 mile catchment area), regardless of whether the care was furnished within the medical treatment facility or by a CHAMPUS provider. In the capitation test facility budgets, while CHAMPUS and O&M funds were ingegrated under authority provided in the appropriation acts, separate amounts were budgeted to defray the costs of providing care within the facility and costs of procuring care from CHAMPUS providers. In effect, CHAMPUS was industrially funded for care provided to beneficiaries residing within the test facility's catchment area.

Evidence from the test suggests the following:

(a) there was an incentive to capture work performed by CHAMPUS providers by either increasing productivity or acquiring/expanding clinical capability when economical. Test rules allowed the facility commander to use either realized, or projected, annualized first year marginal savings to either establish or expand operating capabilities, and/or spend them in a wholly discretionary, legal, manner as a reward for initiative. If the increased in-house costs, decreased CHAMPUS costs, and attendant savings were properly computed, the result was reduced total government costs in the next budget period.

(b) there was no incentive to capture CHAMPUS workload if productivity in a given clinical specialty was already high and it was uneconomical to expand the capability; or, if the professional skills were not available within the military personnel inventory or the civilian labor market; or, if it was uneconomical to establish a capability, as is frequently the case at many small hospitals and clinics throughout the Military Health Care System.

Thus, based on our experience to date, we conclude that industrial funding of CHAMPUS will not, in and of itself, improve productivity across the entire spectrum of Army medical treatment facilities. Further, where productivity was enhanced during the capitation test, it appeared to result from the attraction of the facility's prerogative to reprogram some of the savings to finance otherwise unfunded facility initiatives.

NAVY

Admiral COX. A similar concept was tested in the capitation budgeting trial. While productivity was improved, the flexibilities of allowing transfers of funds between programs and increasing or decreasing civilian staff as necessary were considered the primary incentives for productivity. As long as the managers are restricted in their use of resources little could be gained by industrially funding CHAMPUS at the local level. One recommendation that has merit is to transfer CHAMPUS funding to the Services so that funding changes to improve productity could occur, when appropriate.

AIR FORCE

General MYERS. Yes, but several significant problems with the CHAMPUS program would have to be resolved first. The concept of integrating CHAMPUS and Service O&M-direct funding (which would be required under a CHAMPUS industrial fund concept) was tested as a management incentive under the Capitation Budget test. Based on that experience, such problems as lack of timely data reporting, estimating cash outlays, and lack of control over the source of care (i.e., in-house or civilian) were identified.

PAYMENT OF SERVICE

Senator JEPSEN. Wouldn't it be better for DOD to have one civilian bill paying service instead of four—Army, Navy, Air Force, and CHAMPUS?

ARMY

General MITTEMEYER. We believe that each Service is in the best possible position to equitably, expeditiously, and efficiently adjudicate and reimburse the civilian medical care claims of its own military personnel. The current system ensures that we maintain an awareness of and control over the use of civilian health care sources by active duty Army members. Such awareness and control is essential to maintaining the patient population base and maximizing utilization of the direct care system. We constantly strive to remain operationally cost effective while concurrently supporting our mobilization and readiness requirements. A totally centralized bill paying service would remove this managerial tool from the Services.

NAVY

Admiral COX. The Navy does not have any objections to a central bill paying organization for retired and dependent personnel. For the active duty personnel the bill paying function is secondary to Service control. At the present time, the control of the bill paying function insures only medical services authorized by the Service representative and bonifide medical emergencies are paid with government funds. This also insures that the Services know the status of the Service member and are aware of any medical treatment that could disqualify the Service member for continued active duty.

AIR FORCE

General MYERS. No. Over ten years ago, the Air Force utilized a centralized bill-paying system for emergency care and found the system to be far less responsive to the needs of the patients and the civilian provider community. The lack of a responsive payment system for civilian providers was a major irritant and often resulted in a reluctance on their part to treat military personnel. This lack of responsiveness was caused by a combination of factors, such as communication delays because of the distance from the providers; unusually high volume of vouchers; and the need to contact field organizations of assignment to verify eligibility. As a result, this activity was moved to the base level, where more definitive control and responsiveness could be provided. The establishment of a central bill-paying office at the DOD level would remove the responding activity even further away from the people it serves, compounding the problems previously experienced.

EUROPEAN SYSTEM FOR CONUS

Senator JEPSEN. If one bill paying service has been successful in Europe for 15 years, why won't the same system work in CONUS?

ARMY

General MITTEMEYER. The direct care system provides the overwhelming majority of health care for active duty and dependent personnel in Europe. Even in many of the remote or isolated areas, Government transportation to the nearest Army Forces health care facility is usually available. As a result, only minimal reliance is placed on nonmilitary sources of care. The centralized reimbursement system does function well. However, the geographical and population base differences between Europe and the Continental United States (CONUS), necessitates the use of the present civilian bill paying system as the most effective mechanism.

NAVY

Admiral COX. Active duty use of the civilian health care system in Europe is basically for emergency care and is very small for Navy and Marine Corps.

AIR FORCE

General MYERS. The system to which you are referring is not the only bill-paying service in Europe and has, at best, had only qualified success. Payments made by this system are vlunerable to problems with verification of beneficiary

eligibility and legitimacy of claims. It is, however, a practical mechanism for dealing with the peculiar monetary and language problems associated with CHAMPUS and Centrally Managed Allotment claims. This system has been manageable only because of the low volume of transactions it processes relative to the CONUS; e.g., only 1 percent of total CHAMPUS claims and less than 5 percent of total obligations against the Air Force Centrally Managed Allotment were processed in Europe. Bills from civilian providers for supplemental and cooperative care in Europe are paid by the referring base medical treatment facility, as is done in the CONUS.

Questions Submitted by Senator Sam Nunn

CERTIFICATION OF CIVILIAN DOCTORS

Senator Nunn. Gentlemen, what types of background information do military medical officials require of civilian doctors coming into practice in military medical facilities?

ARMY

General Mittemeyer. Civilian applicants for appointment and active duty in the Army Medical Corps are required to furnish documentary evidence of their medical degree, license to practice, internship and residency completion, board certification and any other relevant advanced education or experience. In addition, their application must contain the results of a personal interview by the appropriate specialty consultant or his designated representative, as well as three letters of recommendation. After careful staff review, applications are considered by a formal Selection Board composed of senior officers convened to recommend candidates for appointment. After approval of the Selection Board results, successful applicants are offered appointment.

NAVY

Admiral Cox. Medical officers at the Bureau of Medicine and Surgery convene weekly to evaluate the recruiting dossier provided by the Recruiting Command on prospective physician appointees. The background evaluation includes a National Security Agency check, letters of evaluation and reference from employers and professional peers, professional qualifications such as board certification and licensure status, a personal professional evaluation by an active duty military physician in that area of medical specialization, and educational transcripts, as well as the routine background information for any officer applicant.

AIR FORCE

General Myers. The Air Force requires extensive background information for civilian doctors coming in to practice in military medical facilities. Information required consists of:

a. An extensive application form listing previous experience, education, personal information, and questions regarding whether the doctor ever had his or her privileges limited, suspended, or withdrawn;

b. A Statement of Personal History which goes back 15 years and lists every place the doctor lived and worked;

c. Three letters of reference—one from the Chief of Staff at the doctor's previous hospital, one from the president of the local medical society where the doctor previously practiced, and one from another member of that same medical society who has knowledge of the doctor's professional performance;

d. Foreign doctors are interviewed by an Active Duty physician or a Reserve medical service liaison officer and a letter of that interview sent to the physician selection board;

e. Copies of medical school diplomas, board certifications, state licensure certification, Residency and Fellowship diplomas.

CASE OF MRS. GREEN

Senator Nunn. General Myers, have there been any more claims filed against the Air Force and Dr. Stanford since the case of Mrs. Green?

General Myers. There has been one claim filed involving surgery allegedly performed by Dr. Stanford at Wilford Hall USAF Medical Center.

LESSONS FROM DR. STANFORD CASE

Senator NUNN. Dr. Beary, the case of Dr. Stanford in the Air Force suggests not only the need to revise the current procedures within the Defense Department for notifying the civilian medical community on the qualifications of military doctors, but also the need for more extensive peer groups review within the military medical system. Do you agree with this conclusion?

Dr. BEARY. First, I agree that DOD procedures for notifying the civilian medical community on the qualifications of military doctors did need to be revised and we have done so. On March 16, 1982, we issued a memorandum to the Military Departments to implement a new policy which would notify appropriate professional regulating bodies, such as the Federation of State Medical Boards, or any medical officer whose employment was terminated under circumstances in which their privileges were suspended, limited or withdrawn at the time of separation. The policy also requires that when a medical officer is ordered to practice in or receive medical training in a military or civilian facility other than that at which his or her credentials file is maintained, the gaining facility will be fully informed of the officer's qualifications, including disclosure of suspension, limitation or withdrawal of privileges.

Second, each of the Military Departments has a peer review system which is in accord with the Joint Commission on Accreditation of Hospitals (JCAH) standards and is similar to, and in some cases more extensive than, practices followed in the civilian community. I have, however, recently established a new Office of Health Program Evaluation and Quality Assurance to assist the Services in reviewing and improving implementation of these systems. I believe this additional assistance will improve the quality of our programs.

Senator NUNN. In the Dr. Stanford case, apparently a number of the military doctors working under Dr. Stanford had serious reservations about Dr. Stanford's competence. Are you, as a medical doctor, satisfied with the ability of the Services' medical establishments to "police themselves"?

Dr. BEARY. The current policies which have been established within the Military Departments with respect to credentialing and peer review are similar to those practices followed in the civilian community. I believe that with the assistance of the new office I have established to assist and monitor the Services in implementing their credentialing and peer review programs an adequate "policing" mechanism will exist within the Services' medical establishment.

Senator NUNN. Does your office, or for that matter any other group outside the military medical departments, have any role in periodically reviewing the qualifications of military doctors to continue practicing?

Dr. BEARY. Our peer review systems are similar to that of the civilian community and conform to the standards of the Joint Commission on Accreditation of Hospitals. I also would like to point out that although the military medical departments are responsible for the actual review of qualifications, both the JCAH and Inspector General's office for each Service periodically audit the procedures under which this review occurs and report any deficiences.

Senator NUNN. What role has your office in OSD taken in encouraging the Military Services to institute more formal peer group review systems?

Dr. BEARY. I believe that the systems currently in effect are quite formal as evidenced by our regulations and policies. However, my new Director for Health Program Evaluation and Quality Assurance will be charged with reviewing the Services peer review systems and will work with the Military Departments to make any necessary changes or improvements.

PEER REVIEW PROCEDURES

Senator NUNN. To each of the Surgeons General, will you please describe the current peer review procedures in each of the military medical departments.

ARMY

General MITTEMEYER. There are four programs at the Army hospital level that involve the peer review of medical care:

Patient Care Assessment (auditing) is the ongoing assessment of professional practice.

Utilization Review is the evaluation of the appropriate use of the facilities resources.

Credentialing is the monitoring of the qualifications of those individuals providing health services.

Risk Management is the program of identifying, analyzing, and reporting known and potential risks to the patient.

These functions are performed by either separate or combined committees. External review of professional practice is conducted by physician members assigned to Inspector General teams and Joint Commission on Accreditation of Hospital survey teams.

NAVY

Admiral Cox. Peer review is conducted at each medical treatment facility, in accordance with the requirements of Bureau instructions in our Health Care Quality Assurance/Risk Management Manual. This program includes procedures for utilization review, medical records review, tissue/surgical case review, blood utilization review, pharmacy and therapeutics review, credentials review, and ancillary service review. These reviews are conducted by committees of practitioners at each facility, and focus on identified problems and corrective actions taken or recommended. Reports of these committees are forwarded to the commanding officer via the Quality Assurance/Risk Management Committee. This process of multi-disciplinary review of the quality and appropriateness of care ensures that command attention is formally drawn to the results.

The credentials review process as described in our Quality Assurance/Risk Management Manual conforms to Joint Commission on Accreditation of Hospitals standards. All practitioners are subject to the credentials review process, including staff physicians, dentists, nurse practitioners, and other paramedical practioners assigned to or employed by the Navy medical treatment facility. The process includes the following steps: evaluation to determine qualifications of applicants for clinical staff membership; delineation of scope of practice for each individual receiving credentials; granting of clinical privileges following credentials review committee recommendation with final approval by the commanding officer; and annual reevaluation to assure clinical competence is maintained at a level consistent with privileges granted.

AIR FORCE

General MYERS. 1. The Air Force operates its peer review program based on the standards of the Joint Commission on Accreditation of Hospitals (JCAH Manual, pp 106–108). Each medical facility has a defined program designed to regularly review, evaluate and monitor medical staff practices and functions. In the Air Force we call it the Quality Assurance Program. It consists of numerous review committees, risk management review and credentials review.

2. Every medical treatment facility (MTF) must have special committees to review health care in conformance with the JCAH. Examples of such committees are:

a. The Health Records Committee which appraises the quality of care rendered as documented in the records.

b. The Infection Control Committee which monitors in-house infection rates in each facility.

c. The Medical Care Evaluation Committee which reviews selected diagnoses, operations and procedures for criteria development, number of completed units, analysis methods, documentation, and follow-up. Also included in this Committee is blood utilization, tissue review and surgical care review.

d. The Pharmacy and Therapeutics Committee which advises the medical staff on acquisition of drugs and monitors the use of antibiotics, controlled drugs, and high value drug items at the facility.

3. Each MTF has a Credentials Review Program which establishes a Credentials Committee to review and award privileges for each civilian and military practitioner in that facility. The program provides for an initial 90-day provisional period during which the practitioner is closely monitored by his or her supervisor. At the end of 90 days, the Credentials Committee meets and formally reviews the qualifications of the practitioner, including his or her professional education, professional experience, letters of reference, and continuing medical education. The Committee then awards specific privileges to that practitioner. These privileges are reviewed annually by the Service Chief, Department Chairperson and the Credentials Committee.

4. Finally, each MTF is required to have a Risk Management Program which establishes a Risk Management Committee to identify and resolve problem areas in health care delivery and to reduce risk-creating incidents. It involves identifying and resolving problems educating and sensitizing hospital personnel, and optimizing patient relations.

Questions Submitted by Senator J. James Exon

DENTAL CHAMPUS

Senator Exon. Dr. Beary, the Administration's fiscal year 1982 Defense budget requests $112 million in fiscal year 1983 for a new program to extend CHAMPUS coverage to dental care.

The committee has still not received any legislative proposal for a dental CHAMPUS program. The deadline under the Budget Act for this committee to report new authorizing legislation requring fiscal year 1983 funds was last May 15.

Does the Defense Department intend to submit legislation to authorize a new CHAMPUS dental program for fiscal year 1983?

Dr. Beary. The Department's legislative proposal is currently under coordination within the Executive Branch. I cannot predict the outcome of that process.

Senator Jepsen. What will the five-year costs of this dental CHAMPUS program be?

Dr. Beary. The cost of the Department's proposed dental program is estimated at $96.7 million in the first year. Subsequent years are estimated as follows: fiscal year 1984—$112.9; fiscal year 1985—$121.0; fiscal year 1986—$130.7; and fiscal year 1987—$140.6.

WARTIME DRAFT OF HEALTH PROFESSIONALS

Senator Exon. Dr. Beary, last year your predecessor, Dr. John Moxley told the Congress that the Defense Department and the Selective Service were working "to insure a timely wartime draft of health professionals including induction by medical specialty and reduction of pre-deployment training requirements."

Dr. Moxley went on to say that the Defense Department and the Selective Service were drafting a legislative proposal to address these issues that would be completed by February, 1982.

What progress have you made on this project to ensure that we will have sufficient numbers of doctors in uniform if this country ever goes to war?

Have the Selective Service and the Department of Defense completed work on a proposal that would speed up the process of drafting doctors and other health professionals in an emergency?

Dr. Beary. The Defense Department, along with the Selective Service, Department of Health and Human Services, and the Federal Emergency Management Agency, have developed a legislative proposal which will meet our health personnel mobilization needs. At present we are preparing to present this proposal to the medical community to gain their support. We expect to submit the package to OMB in October and, assuming OMB concurrence, to Congress in January 1983.

CONSOLIDATION OF MEDICAL FUNCTIONS

Senator Exon. Dr. Beary, there have been recent reports that the Defense Department has rejected a proposal to create a Defense Health Agency to consolidate all peacetime military medical functions.

Was this proposal to create a Defense Health Agency one made by your office? Why was it rejected?

Dr. Beary. No such proposal has been formally proposed or rejected. I have been tasked by the Secretary's Council on Integrity and Management Improvement to examine the structure and organization of the entire military medical system with the aim being to identify methods to improve effectiveness and accountability. My staff has developed a number of options for consideration by the Council and I will be presenting them later this month.

DUPLICATION AND OVERLAP

Senator Exon. Dr. Beary, do you think that there is currently a significant amount of duplication and overlap of functions with the three separate military medical departments?

Dr. BEARY. This criticism has been raised in the past and concerns us. We are attempting to eliminate duplication where we find it. The goal is to have CHAMPUS and the three medical services performing as a well integrated system.

Senator EXON. What is your office doing to eliminate this duplication and overlap?

Dr. BEARY. The current resource allocation system, follows command channels within each military department. However, the regionalization system is being strengthened and will include formal reporting requirements from each Tri-service region. Also, a Health Information System is being implemented to provide timely management information.

I have initiated a number of other actions ranging from the memorandum regarding CHAMPUS growth mentioned in my Statement to hosting a number of planning sessions with members of my staff, the Service Secretariats and the three Surgeons General to discuss and develop long-range goals and objectives for the military medical system.

DEFENSE HEALTH AGENCY MANAGEMENT

Senator EXON. Dr. Beary, do you think a single Defense Health Agency managing all peacetime military medical functions would save taxpayers' dollars and provide more efficient delivery of medical care?

Dr. BEARY. A number of recent studies have addressed this issue of centralization with varied recommendations. While the DOD/HEW/OMB Military Health Care Study of 1975 clearly called for a central entity within DOD to oversee planning and resource allocation efforts; others, notably the so-called Rice Report of 1979, recommended a number of management improvements without changing the current decentralized system. The Secretary's Council on Integrity and Management Improvement has indicated that at this time it favors this latter approach and my recommendations on strengthening regionalization support this preliminary decision. However, the Rice Report points out, if these efforts produce insufficient improvements then the question of centralization should be re-examined.

Senator EXON. Do the Surgeons General agree with your views on this matter?

Dr. BEARY. Yes, Senator, I have received full support for my efforts to strengthen regionalization.

REGIONALIZATION OF MILITARY MEDICAL CARE

Senator EXON. Dr. Beary, what will your proposals for greater regionalization of military medical care accomplish in the way of reducing the current duplication and overlap within the three military medical departments?

Dr. BEARY. By strengthening regionalization my aim is to eliminate needless duplication in facility construction, equipment acquisition and utilization, and to promote more inter-service sharing particularly in areas where two or more medical catchments overlap.

Senator JEPSEN. Thank you, gentlemen. The hearing is adjourned.

[Whereupon, at 4:20 p.m. the subcommittee adjourned, to reconvene subject to the call of the Chair.]

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